

BIOMEDICAL RACIAL PROFILING: A DISEASE MORE DEADLY THAN THE
PERCEIVED BARRIER TO BREAST CANCER SCREENING AND TREATMENT
FOR AFRICAN AMERICAN WOMEN-LATE STAGE DIAGNOSIS.

By

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Sheila Belinda Jeffers

This document is dedicated to my loving mother Mattie B. Jeffers.

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By

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INTRODUCTION: Research on breast cancer screening and treatment among African American women usually has a focus on three major areas, structural issues, such as transportation; cultural issues such as health beliefs or behavioral issues such as late-stage diagnosis. The correlation between self-identity, race and the ability to seek screening and treatment has not been made. A number of political, economic and social factors connected to identity influence an individuals' decision to avoid or delay preventative or curative treatment. This project describes how the process used to teach African American women to engender race continues to affect their decision to seek screening and treatment for breast cancer.

METHODS: Participants for this study were recruited using different techniques including random, (e.g., newspapers, health fairs) sampling from a community in central Florida, purposive (invitations to a Summit) throughout the

state of Florida and snowball sampling at two ethnic sensitive health conferences (5 meetings). The sample consisted of 202 African American women including those participating in surveys, face to face interviews and focus groups. In addition 10 non African American female health care providers and two male health care providers, one white, one black participated in focus groups. Discussions were encouraged in focus groups using videotapes and standardized patients.

SUMMARY: The basis of the fears to seek treatment by black women is misinterpreted. Assumptions are made by patients and providers based on previous experience and historical data. Women feel they are denied full access to resources because of their race. The perception is information and care is dispersed differently depending upon race. Biomedical racial profiling is an issue for many women.

CONCLUSION: Patients and providers share feelings of powerlessness, connected to identity. Doctors feel time constraints limit their ability to create a more trusting relationship in order to explore patient's health beliefs. Women are discouraged they do not receive equal treatment. Patients and providers want to know how to better negotiate their positions during encounters. Putting issues of biomedical racial profiling at the forefront will direct attention towards issues of identity, power, and control of resources, promoting better communication, access and equality in care.

CHAPTER 1 SHH! LISTEN TO THE WHISPERS

Introduction

A “No Talk Rule” is practiced in the African American culture, leaving a gap in the literature on African American women and breast cancer. Outreach programs such as Save Our Sisters, Sister's Network, and The Witness Project®, to name a few were established during the 1980s and 1990s in response to this silence. The intentions of the programs are to empower black women by encouraging them to abandon their silence or the practice of whispering about breast cancer. Women are encouraged in the programs to find their voice.

The Witness Project® is an educational and support program where women exchanged whispers for testimonials.¹ Sisters Network, founded by a black breast cancer survivor, Karen Jackson encourages women by using modeling behavior. Her program considers every aspect of the woman's life from cosmetic needs to educational information. These national organizations, as well as community-based organizations such as Brothers and Sisters against Cancer, a local organization in Florida, are successful in providing hope for positive

¹Testimony serves two major purposes: it is a familiar process allowing African American women to reconnect with their spirituality. It encourages participation through familiarity. Finally, it is a form of empowerment for African American women. They tell their side of the story in a meaningful manner. Deborah Erwin and Eric Bailey two anthropologists found testimony to be effective means of communication in African American communities.

outcomes for black women.² After reviewing the literature on black women, breast cancer and outreach it became obvious that a full discussion on unequal treatment and breast cancer is missing from the literature. From the point of view of an African American female researcher an obvious question that has not been answered in the literature is how does the race of a woman affect her ability to obtain treatment for breast cancer?

Aim of Study

The specific aim of this study is to show that African American women traditionally have been silenced about their race in the health care system. They have been marginalized in many ways because of their race and gender (Rosser 1994). Power and domination is used against them to teach them appropriate roles (Bennett 1975). It is recorded that historically, blacks were subjected to a doctor/patient dichotomy lacking cultural sensitivity. This negates the assumption that common sense dichotomies of illness/patient; doctor/treatment are “symbolic frameworks” (Laitin 1986). These dichotomies prove to be efficacious when they are static. However blacks’ roles have been fluid. Furthermore, blacks have been objectified in the medical system. Traditionally, these dichotomies have not worked well for this population (Byman, 1991).

The social construction of race made the role as a patient difficult to define for black women and her providers (Savitt 1978, Young 1983, Lannin 1997, Jeffers 2002). A difficult task for blacks is receiving a classification of being sick or being a patient (Hughes-Gaston and Porter 2001, Chevarley and White 1997,

² Data collected on black women in the health care system is not divided according to ethnic origin. Therefore the terms African American and black are used interchangeably in this study.

Eley et al. 1994, O'Malley et al. 1997, 2001, Mathews et al. 1994). Black women struggled to receive a classification of patient as Ford (1999) explains, because being sick or having symptoms is not what makes one sick or a patient. It is not until an individual is assigned the classification of patient after seeking professional help.

Previous studies show African American women do not receive referrals into the system at the same rate as other women (O'Malley et al. 2001, Nattinger et al. 1992). They are not classified as patients early. Mathews et al.(1994) study shows the danger in providers having a cavalier attitude towards the patient.. Women leave their encounters unhappy or confused assuming the problem is related to racial or cultural issues as indicated studies (Mathews et al. 1994, Wardlow and Curry 1996). When they return the disease may be in a more aggressive state (Mathews et al.1994). A more recent study showed the significance of doctor recommendations among African American populations. It was determined African American women respond better to doctor recommendations for screening than white women who rely more on guidelines (Lannin 2002).

Other variances in treatment are found in studies on geographic differences (Farrow et al. 1992). In a study of 8,399 non-Hispanic white, 324 Hispanic, and 1174 black women with breast cancer in nine areas race and age proved to be a significant factors. In another study, Canto et al. (2001) studied geographic variations over two separate four-year periods, from 1986 to 1990 and from 1991 to 1995 identifying stages of diagnosis. Their study shows socioeconomic status,

access to care and type of treatment. Researchers know that race is not a one-dimensional variable (Bernard 1995). Race affects several endogenous and exogenous factors including health. However the degree by which race affects health outcomes remains uncertain.

It is known that race, is a social construct that influence sickness, illness and disease (Singer and Baer 1995). Sickness, illness and disease are a cultural construct influenced by perceptions about patients (Brown 1997). Identity is associated with race (Feagin 1994). Sickness illness and disease correlates with identity (see Chapter 2). The significance between identity of black women and stage of diagnosis is investigated in this study.

Many studies place focus on compliance among blacks in the health care system (Friere et al. 2002, Rattthore et al. 2002, Heidenrich et al 2002, Wilson et al. 2002, Hyman and Pavlik 2002, Rawl et al. 2000, Siegel and Gorey 1997, Leggat et al. 1997, Shea et al.1992). Other studies about women and breast cancer point to lack of knowledge as a major factor (Campbell, 2002, Crump et al. 2000, Lawson 1998, Ashing-Girwing 1999, Lannin et al. 1998, Davis et al. 1996, Douglas et al. 1995). There is another body of knowledge with a concentration on fear of fatalism as the barrier to screening and treatments (Guidry, et al. 2003, Adams et al. 2001, Padgett et al. 2001, Phillips et al. 1999, Mathews et al 1998, Wardlow and Curry 1996). The many ways compliance, knowledge and fear may be correlated to barriers to care remain. Perhaps the silence, which prevails in the black community, the “No Talk” rule, acts as a barrier. Silence or even whispers is a learned behavior that accompanied the

alienation during the social division of labor. The significance of silence among this population is muted because of the profiles and stereotypes of the social theorists Karl Marx, Max Weber, W.E. B Dubois, Michael Foucault who passionately approached the subject.

Western medicine emerged into the African [American] culture during slavery, a time when whispers were the major form of communication. This pattern of communication was developed as survival techniques (Savitt 1978, Fox-Genovese 1988, Baker 1998, Brewster 1997). This culture of communication used by Black mothers, daughters, granddaughters, aunts, sisters, cousins, girlfriends, co-workers, and neighbors is perceived as avoiding the Western medical system (Phillips 1999). Audre Lorde (1984) explains we use our past as a seed to our present. Whispers are used to plant seeds.

Women whisper about what they fear. Fear of fatalism is cited throughout the breast cancer literature (Wardlow and Curry 1996). Women are more likely to survive breast cancer than die from it if it is detected early.³ What has African American women so afraid?

In the literature much of the attention is placed on necessary behavioral changes to encourage early screening and treatment. African American women's current behaviors are interpreted as lacking knowledge, having cultural barriers, or choosing to die from a treatable disease, breast cancer (Burnett et al. 1995, Chang et al. 1996, Chen et al. 1994, Chevarley et al. 1997, Danigelis et al. 1995, Hughes-Gaston (2001) and, Michalski et al. 1997). The medical system points to

³ Breast cancer has nearly a 97 percent survival rate if detected early according to the American Cancer Society.

lack of transportation, referrals, insurance, or geographic variations (Blake 1984, Branch 1997 Brewster 1997, Burnett 1995, Chang et al. 1996, Crump 2000, Nattinger et al. 1992, Perkoff 1997). Limited in the literature is the way racism acts as a structural barrier affecting black patients access to care (Barbee 1994, Dennis 1999, Gary 1996, Jeffers 2001). This is largely because as scientists, we have not listened objectively to the whispers.

Anthropologists currently studying breast cancer place more focus on ethno medical beliefs and traditional beliefs (Mathews et al. 1994, Mathews 2000, Chavez et al. 1995. Erwin et al.1996, 1999) than social controls. Erwin et al. (1995a, 1995b) use a critical approach to assess intervention methods. I also use a critical analysis to interpret fears black women hold about getting and treating breast cancer.

Interpreting Fears

"Is it true they really have to cut your breast off if you have breast cancer?" During the first focus group this question was whispered to the researcher after sitting through a short educational session and having a one-hour discussion on breast cancer. The individual still could not articulate this question to the group because of her fears.

It is important to listen to the whispers because the whispers are about more than breast cancer. The question the researcher asked that prompted the whisper was, "Do you think black women are treated differently from other women in the health care system?" In each of the focus group sessions, this specific question prompted whispers. A second point is, it is not enough to recognize fear of fatalism as a barrier to care. The exhaustive data collection and

review of the literature show there are legitimate reasons for women to be fearful. Blacks are sicker than whites and die more often than whites according to a recent Institute of Medicine Report (2002). This is a lived experience of women participating in this study. The cause of the fears should be cited.

Women in this study have clear perceptions about why people in their neighborhoods, churches and families die from diseases like breast cancer although they do not get it as often as white women. These ideas are contained in the whispers. There is evidence that socioeconomic and educational levels alone will not account for the variance in screening, morbidity and mortality rates for breast cancer among black women (Cozier et al. 2001). Some of the deepest truths come from within the whispers.

Overview of Breast Cancer

Clear attempts have been made to dispel myths held by black women about breast cancer (Lannin et al. 1998, Erwin et al. 1996, Mathews et al. 1994,). Women remain unsure about the etiology of breast cancer. Cancer is a general term used for more than 100 different types of diseases (American Cancer Society 2000). Cancers are cells that grow out of control.

Cells normally divide and replace themselves in an orderly manner. Cells that lose their ability to limit their growth rate, growing aggressively and rapidly forming too much tissue turn into tumors that invade and destroy surrounding tissue (American Cancer Society 2000). They may become cancerous (American Cancer Society 2000). Tumors can be either malignant or benign. Malignant tumors are cancerous. Benign tumors are not cancerous according to the

National Cancer Institute. The exact cause of breast cancer is still unknown; therefore it is difficult to define the disease cancer in lay terms.

Affecting the way blacks may approach cancer is the fact that medicine use pathologically based definitions to describe illness. Hierarchical superiors (men) assign classifications for the weak (others) (Perkoff 1997). Thus, a medical hegemonic system is created including the use of prescription drugs, surgical techniques and life sustaining technology, which sets the medical culture apart from other cultures (Hahn 1995, Baer 1997).

Hierarchical systematically structured classifications of disease have been around since the beginning of medicine. This was consolidated with the class and race system established in the dominant society. Studies show blacks were isolated by not being afforded access to the medical system or proper use of these prescription drugs (Harris 1989, Savitt 1999). Hence, the relationship between blacks and medicine differs because of the omnipresence of power a theory Foucault (2000) discuss in depth in his work.

Theoretical Framework

The theoretical framework is critical medical anthropology to show the imbalance in power. Power is operationalized using the variables race and gender. This affects the sickness experience. The ideology is that race is a complex variable affecting the way stressors enter and exit the lives of individuals (Lieberman, 1997). It is so complex, even anthropologists cannot agree on whether it is a biological construct or a social construct. Anthropologists agree race is an important factor dictating health outcomes. Other scientists provide evidence (Feagin 2000, Feagin and Sikes 1994, Smedley, Stith and Nelson

2002)) that race is a contributing factor influencing health disparities. The work of Kant and Hume shows development of race was a means of maintaining power and control (Gates 1986, Collins 1997, Bennett 1975, Dubois 1902) Still, the inequalities caused by power, and the forms of resistance as a result of power are omitted from the literature (Foucault 2000).

Studies reveal, race is used as a marker in health. It is used to compartmentalize patients (Perkoff 1997). Patients are identified by age, race, gender and illness (Branch 1997). Race for anthropologists is often regarded as part of the demographic description. In this work race is a political as well as social construct.

Few researchers consider all the meaningful ways race impacts the conceptualization of a disease. Race became more significant in this study when the participants argued their difference; their fractured identity affected their poor outcomes. Politically, economically and socially, the conceptualization women have about their ability to survive a diagnosis of breast cancer is connected to their identity. Particularly, their fear of fatalism is related to being assigned an inferior sociopolitical position. Women are threatened by a medical hegemony that too often misinterprets their cautiousness for unawareness..

Studies show Eurocentric culture falls short on valuing lifestyles or life experiences of non-indigenous groups (Mwaria 2001, Lannin et al 1998, Rosser 1984, 1994.) Rosser (1984) argues historically, inferior treatment in the medical system kept black women at the margin of the dominant culture. Black women are so far outside of the cultural core sometimes they are even invisible (St. Jean

and Feagin 1998). In a study unrelated to medicine, Rollins (1985) gives an example of being invisible. In her study on race she was employed as a housekeeper, for her fieldwork. She gives an account of working in a cold apartment on a regular basis. Her employers turned the heat turned off each day in the apartment when they departed for work, as though it were vacant. Based on the data and hearing the women discuss a life of invisibility the conclusions drawn are that unequal treatment is due to biomedical racial profiling.

Biomedical racial profiling is concerned with poor social positioning. This study neither portrays the strengths or inadequacies of patient-provider communications or barriers to care. Rather this research uses an emic and etic approach to interpret the symphony of suffering of African American women. This work deals with the cultural realities of the disease breast cancer for black women from a political, social and economic perspective (Brown 1988). In the hospital, in the doctor's office, at home, it interprets how individuals must internalize power, race, gender, sickness, and disease in order to seek care (Singer and Baer 1995).

The understanding is that the pathogen in the body is an integral part of the disease process. But race and gender also impacts the disease process (Rosser, 1984, Mwaria 2002, Lorde 1984). The association between screening and treatment or delays and race goes beyond the obvious barriers to care. Breast cancer is one of the worse diseases a woman can contract because it assaults the core of her sexuality (Nattinger et al. 1992). Black women traditionally have a different experience in this society. Collins (1997) work

describes a fractured identity. Historical accounts show they endured horrific attacks on black bodies during slavery affecting the embodiment of femininity among black women (Bennett 1975, Fox-Genovese 1988, DuBois 1985, Collins 1997, hooks 1991, 1990, 1995, 1996). These women inherited scars from attacks during slavery (Dubois 1985, Blassingame 1979). Having to accept another unjustifiable attack on her feminine role may be too overwhelming. I work within the theoretical confines of critical medical anthropology to record how race matters in the fight against breast cancer for black women.

In this work I argue that historically black women were more vulnerable than other women in the medical system (Savitt 1978). Foucault (1976) explains that power is continuous; there is multiplicity in power. Power involves struggle. Individuals are insider or outside of power. Black women are outside of power in every respect. Understandably, they cautiously approach screening and treatment procedures (Matthews 2000, 1998). I chose critical medical anthropology because it shows their exteriority in power when the political economy of health is considered. To address race and racism in health power and resistance to power must be placed at the forefront. Racism implies a dominate/subordinate group. This work shows there was capital gain from the use of black women. To demonstrate how power was acquired and control maintained I pose specific questions.

The research questions are as follows:

1. What are the most influential messages black women receive about being a patient?
2. How do these messages originate?

3. How does this information differ from what is received by other women?
4. How does this information influence decisions?
5. What is their overall impression of their ability to survive breast cancer in the western medical health care system?

For this study a sample population was obtained representing women and providers carrying a heavy burden for health. African American women were selected across all socioeconomic and educational backgrounds and from different geographic areas. Some women were never diagnosed with breast cancer. Others were survivors, some fighting the disease more than once. Several women were underprivileged politically, economically and socially. There was another group of women consisting of professionals such as judges, lawyers and academicians.

Providers were well represented including males and females, African American and whites. The study captures the feelings of patients and providers. Providers share feelings of being “powerless” with their patients. Providers wondered how to better treat black women for breast cancer. Women want to be treated better. There was one major theme among women and providers alike, “better treatment.”

Black women interviewed for this work, never diagnosed with breast cancer, expressed feelings of being profiled as a result of receiving unequal care for other conditions. Some heard horrible stories about breast cancer. This creates a high level of fear that they may also receive unequal treatment for breast cancer. If diagnosed with breast cancer, they feared they may have poor outcomes if survivorship depended on this medical system they heard historically failed

minorities. This has become a major deterrent for the women and should be defined as a major concern for the nation.

Among survivors there were those who also experienced racial profiling, if not directly then indirectly. Survivors tell of survivorship, "in spite of...". Based on the survivors' stories, race is a concern, but cancer became the imminent threat. Holly Mathews (2000) has consistently stated the word survivorship among black women has yet to be defined. This says a major barrier to screening, treatment, and survivorship is the issue of race.

Racial Profiling

Racial profiling is not a new perspective. The problem is ethnocentric in that it is not confined to African Americans. As long as individuals differed racial profiling was solidly practiced (Derbyshire 2000). According to Feagin (2000) racial profiling is harmonizing behavior used towards individuals. Racial profiling is a way of dealing with individuals who are "out of place" (Feagin 2000) and recognizable by visual markers, mainly phenotypic characteristics, such as skin color. Recognizing that biomedicine is both raced and gendered, being African American and female would increase an individual's probability of being "out of place." Savitt's (1978) work shows how blacks were positioned, "out of place". His work shows how the poor and the sickest were used as experimental subjects with blacks being used for demonstration projects more often than whites. This is a good example of being racially profiled in the biomedical system. The term biomedical racial profiling is a term developed to explain the ideology of a variation in treatment based on race. Throughout this work biomedical racial profiling is used to identify an ascribed body of individuals in powerful positions in

the medical community possessing the prerogative to demonstrate discriminatory and prejudicial behavior against particular racial [ethnic] group[s]. These powerful individuals reflect their ability to control and dominate the outcome of the state of a particular racial [ethnic] group by sparingly allocating resources to profiled groups. Biomedical racial profiling can be practiced against any race without regard to the race of disease. For the purpose of this study African American women are perceived as the targeted population.

Racial profiling is a complex phenomenon. It is as complex as race. For the purposes of this study it is the product of discrimination and more powerful than racism and prejudice, viewing one race as better than the other. All of these acts take refuge under the umbrella of institutional racism but scientists writing on race define institutional racism as using social, political, economic and religious structures for gain of power and control and at the expense of others (Feagin 2000, Mann 1993). On a political, social and economic level these acts are connected to the status of the individual.

Biomedical Racial Profiling

I define biomedical racial profiling as the use of visual markers as indicators to rationalize and operationalize stereotypical thoughts and images about groups in order to administer unequal treatment. Examples of visual markers include skin color, weight, and other phenotypical characteristics. Disparate treatment based on these markers indicated in the definition includes but is not limited to withholding information, technology or procedures from a group. Biomedical racial profiling has a series of aims and goals. There are specific tactics involved in enacting biomedical racial profiling. This is related to power. This differs from a

stereotype, which is defined as the use of social categories such as age, race or sex to acquire process or recall information about others (Smedley, Stith and Nelson 2002). An individual does not need to power to stereotype other individuals. This differs from prejudice, which is the negative attitude against individuals based on their group membership (Smedley, Stith and Nelson 2002). An individual can be prejudice without having power.

The type of treatment administered to the group is directly related to the perpetuation of their poor health status, poor quality of life and outcomes that can result in untimely destruction of the group. Behaviors of providers during assessment and diagnosis, referrals, aggressive/nonaggressive treatment or unequal treatment correlate with expected behaviors of the patient. For example, the literature shows black women are not referred for follow up care because providers have to take time to educate the women and the women may not follow-up (Ekah 2002, Geiger 2002).

The claim can be made that unequal treatment based on race is historical in nature. Furthermore, it has a consistent pattern. The dominant group uses power, domination and control as justification for the unequal treatment. For the purpose of this study race is used as a status variable (Reid and Comas Diaz 1990).

Breakdown of the Chapters

Chapter 2 is the literature review giving a brief overview of the cultural construction of health disparities. This takes a look at the overall health status of blacks and whites demonstrating how health disparities are more prevalent in minorities for six major diseases. Included in this chapter is the epidemiology of

breast cancer. This chapter shows the variance in disparity rates between the races. Chapter 3 is a historical look at the socialization process of women, focusing on an evaluation of how black women were identified in the dominant culture. The objective is to show that the profile given to black women is historically based on a consistent pattern of unequal treatment associated with race. Most physicians find mistreatment or unequal treatment an abomination. It goes against their ethical and professional beliefs. Chapter 4 is the research, methods and design. Chapter 5 is a presentation of the setting explaining why the fieldwork was conducted in the location selected. Chapter 6 is an analysis of the data with the findings and Chapter 7 is the final discussion about the research. Within these final chapters the ways in which the disease racial profiling came to contaminate the medical system is revealed.

CHAPTER 2 HEALTH DISPARITIES BEYOND BREAST CANCER

Introduction

Blacks bear a heavy burden for sickness, illness, and disease in America. They die at earlier ages from several major diseases compared to whites, according to a Institute of Medicine Report (Smedley, Stith and Nelson 2002). President William "Bill" Clinton striving to improve the health status of the nation recognized a serious problem existed. He commissioned Congress to appoint a team of researchers to identify the causes and later to develop strategies to eliminate the problem. The problem was identified as health disparities (Smedley, Stith and Nelson, 2002). The report listed political and economic factors as major contributors for the health disparities over biological factors (Smedley, Stith and Nelson 2002).

The reasons for the difference in mortality rates are multifactorial. Closer scrutiny shows at every level a combination of variables contributes to poor outcomes, including biological, environmental, social, economic, and political factors. Contributing to the differences in morbidity and mortality rates for major disease is racism. The political economy of health is the framework under which the differences are reviewed. The problems are analyzed by looking at exogenous and endogenous factors that perpetuate the differences in health outcomes between the races.

I argue that medical hegemony suggests a certain moral and prestigious order in the medical culture making the inferior treatment of minorities permissible. Medical hegemony amplified the poor quality of care received by blacks and other minorities in the health care system. Evidence shows disequilibriums and coercion was used against minority populations during the developmental stages of medicine (Savitt 1975). There was a strong need to maintain this power of influence (Molnar 1992). Those in positions of power manipulated the outcomes of blacks and other minorities, by profiling the groups as having deficiencies rather than receiving deficient care. These expressions are voiced in the findings (see Chapter 3) in this study.

This chapter begins by showing the distribution of power in the levels of the health care system. Next, a landscape of the health status of blacks is provided showing that they die more often than any other racial/ethnic group for several major diseases. An underlying message throughout this portion of the chapter is a profile of blacks presented politically, economically and historically in the medical system as inferior. The pattern of reporting outcomes of blacks shows they are portrayed as sicker [weaker] indicating they are not worthy of equal access to information, state of the art technology, advanced level education or optimal treatment. Above and beyond other racial groups they are racially profiled in the medical system as the most inferior group. Three goals are achieved when information is reported in this manner. The political agenda of unequal treatment is achieved; a consistent pattern of oppression is maintained and the historical nature of exploitation is secured.

To put this in perspective a specific disease, breast cancer, is considered. Breast cancer is a debilitating gender based disease. The threat to young black women appears to be imminent to young black women. They die at younger ages than white women and faster than white women once diagnosed with the disease (American Cancer Society 2001). Much like the other diseases the evidence will show a pattern of racial disparities between black and white women for this disease.

Principles of Health Care System

Health is a social construct with variations in the interpretation of disease, sickness and illness (Hahn 1995). Cultural beliefs influence interpretation of disease, sickness and illness because as Kleinman points to in his study between 70 and 90 percent of episodes of sickness in the United States are not treated by medical professionals (Hahn 1995). Other research shows health care systems are constructed based on what people feel about sickness (Hahn 1995), where the power lies (Singer and Baer 1995) and how it is delegated and how it is expressed (Singer and Baer 1995). Among anthropologists there is agreement that division of labor, production and reproduction, women's workloads, power and control of goods influence the relationship women have in the health care systems (Sahlins 1968, Harris 1968, Rosser 1984). Sacks (1979) review of Engels work points to the fact that because class societies focus on economy, women are both circumscribed and subordinated so that health becomes associated with maintenance of property.

Western health has a focus on relief of suffering as well as protecting resources by maintaining control over infectious disease (Hahn 1995). In the

West there is a medical hegemony. The belief is Western medicine is all-powerful over any other medical system. Therefore, a more important role of Western medicine is to symbolize power and domination over every level of health care and health related behaviors.

Singer and Baer (1995) give a portrayal of the medical system. They developed a model showing the four levels of analysis in the health care system (Figure 2.1). This model shows power and control flows from the macro-social level down to the individual level. At the top level of analysis is the macro-level. The social and biopsychosocial relationship at this level is centered on production and reproduction [different from women's responsibilities], with interactions between the larger organizations for example, insurance agencies, such as pharmaceuticals, hospital construction (Baer, Singer and Sussman 1997, Salk et al.1992) In their work on women, Salk et al. (1992) explain that the main objective of individuals holding key positions at this level is to keep the system free of government control. At this level, insurance companies compete with government agencies, such as Medicare or Medicaid for control. Also, companies reward hospitals and physicians for complying with policies by providing fees for service (Salk et al. 1992). Similarly, drug companies prepare samples and court the doctors and hospitals (Salk et al. 1992). The primary factor associated with interest here is with the social positioning of populations in relation to these organizations.

The next level is the intermediate level focusing on the relationship between administration and providers. At this level the regional political economy of health

(Singer and Baer 1995) is the focus. Attention is directed at the distribution of power within the medical institution. Highly paid physicians and administrators make regulations about the type of care provided to patients and the number of patients treated per health care provider (Salk et al. 1992).

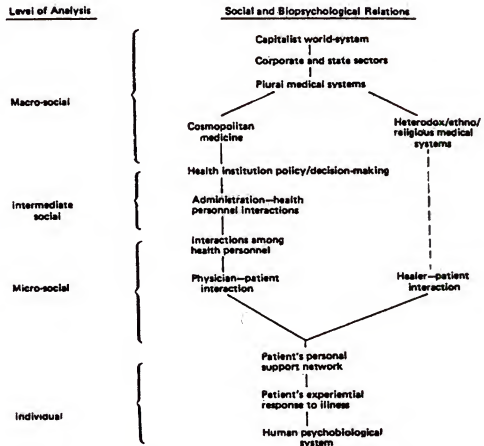


Figure 2.1 Levels of Analysis in Health

health care practitioners, nurse-practitioners and physician specialists (Singer and Baer 1995, Salk et al. 1992)

Categories are established for each profession. It is determined at this level that nurses care for patients and doctors treat patients, indicating that at this level there is an imbalance in the relationship between health care providers (Salk et

al. 1992, Barbee 1994). Power of control is undoubtedly demonstrated at this level. How are the lines drawn? Who maintains control of resources? Concerns are raised about where treatment is administered (Salk et al 1992, Barbee 1994), how treatment is provided and the cost of treatment. What is noteworthy here is despite the provider having the monopoly on medical knowledge needed for production or maintenance of the institution at this level their power is compromised by administration (Singer and Baer 1995, Salk et al. 1992, Barbee 1994, Dennis 1994). Singer and Baer (1995) in their development of the construct that even providers are subjected to administrative authority and bureaucratic demands, despite the expectations to make life-saving decisions.

The level most patients are familiar with is the third level, the micro-social level (Singer and Baer 1995). The provider is in position of power at this level. In this position the health care provider makes the decisions as the authoritarian. Interrelationships between providers and nurses; professionals and paraprofessionals, patients and providers are considered here.

The last level is the individual level discussing the individual or sufferer's experience (Singer and Baer 1995). This level promotes the difference in the interpersonal relationships between the patient and providers. In the literature on women's health, Salk et al. (1992) identify the problem as having "a profound inequality on every level, an exaggeration of power imbalance is in this [patient/provider] relationship". Even at this level, Salk et al. (1992), felt the patients voice is not heard. Their work found that when women complain, doctors doubt their word simply because they are women (Salk et al. 1992). It is no

wonder black women who were marginalized at a greater extent in the system (Rosser 1984) feel ignored (hooks 1991, Barbee 1994, Collins 1997, Jeffers 1998, 2002) and do not engage in the system as often as others (Wardlow and Curry 1996). These four levels show how far removed the patient is from having power and control of their body. Dividing the health care system into levels gives visualization to how burdensome obtaining care is for black women, who are not a part of the system.

Health Disparities

The major governing bodies, American Medical Association, and National Institute of Health define health disparities as: differences in incidence, prevalence, mortality and the burden of disease, and other health conditions among specific populations, based on access, utilization, and prescription of health care services (American Medical Association 2002, National Institutes of Health 2002, Medicine and Public Health 2002). The Institute of Medicine research team identified unequal treatment as a major contributor for the health disparities.

According to the reports, barriers at every level of the health care system caused health disparities. On February 21, 1998 President William "Bill" Clinton challenged the nation to focus on six diseases believed to be killing minority populations. These diseases were identified as

- infant mortality
- cancer screening and management
- cardiovascular disease
- diabetes
- HIV/infection/AIDS
- Immunizations

Certainly, blacks are not the only ethnic group threatened by the disease (Smedley, Stith and Nelson 2002). Several minority groups experience greater burdens for these diseases than whites. Also, not only is under use of care identified as a problem, but overuse of care is problematic for minority populations in relation to diseases (Smedly, Stith and Nelson 2002).

Researchers found a systemic relationship between unequal treatment and certain racial groups. Nattinger et al. (1992) work shows Blacks are more likely to receive a mastectomy than lumpectomy, chemotherapy and radiation. This falls under the rubric of curing breast cancer through radical means, the very situation most women in this study fear. Historical, political and economic factors seem to perpetuate the discrepancies between the races. This may go unnoticed because the biological differences appearing in the literature.

Epidemiological Factors

Blacks have an excess number of deaths for every major illness. The average number of excess deaths per day from 1980 to 1998 relative to whites increased by 20 percent according to the Institute of Medicine (2002) report. Between 1940 and 1999 blacks experienced 4.3 to 4.5 million premature deaths relative to whites (Levine et al. 2001). In a 1990 report from the National Center for Health Statistics the average life expectancy of African American women was more than five years less than that of European American women (National Institute of Health 1996) (Table 2.1). The National Institute of Health reports show Blacks, Native Americans, Alaskan Natives and Hispanics all had death rates above the national rate in 1996 (7.2 per 1,000 live births). Among these populations, blacks surpassed all ethnic racial groups by having the highest

mortality rate at 14.2 per 1,000 in 1996, which was nearly 2.5 times (6.0 per 1,000) that of whites. Native Americans' rate of 9.0 per 1,000 and Hispanics' rate of 7.6 per 1,000⁴) are also higher

The evidence points to minorities suffering disproportionately from several life threatening diseases (National Institute Health 2002). Biological factors can be identified according to racial groups. Of all the populations, African Americans have the greatest burden for four of the six diseases identified: infant mortality, cardiovascular disease, diabetes and cancer (Smedley, Stith and Nelson 2002). Native Americans/Alaskans have lower life expectancy. Hispanics who also have higher mortality rates than whites; Korean Americans who have higher rates of stomach cancer; and Vietnamese women who have higher rates of cervical cancer than white women (Smedley, Stith and Nelson 2002, National Institutes of Health 2002). When gender is considered African American women are among the sickest people in the nation (American Medical Association, 2002).

A different way to state the problem is blacks suffer from cardiovascular disease and cancer more frequently than from any other diseases (see table 2.1). More than 50 percent of the deaths (50.1%) were attributed to just these two diseases in 1997. This does not focus should not be taken away from other illness or disease. A review of the literature from a biopoliticoeconomic perspective shows the magnitude of the problem is much more serious than suspected.

⁴These numbers do not reflect the diverse groups in the Native American or Hispanic populations.

Table 2.1 Leading Causes of Death Among African Americans, U.S., 1997

All Ages Cause of Death	Number of Deaths	Death Rate per 100,000 Population	% of Total Deaths
Heart Disease	77,174	258.1	27.9
Cancer	61,333	213.4	22.2
Cerebrovascular Diseases	18,131	59.9	6.6
Accidents	12,665	37.2	4.6
Diabetes	11,130	38.4	4.0
All Causes	276,520	903.1	100.0

Source: American Cancer Society, Surveillance Research, 2000

than whites. Epidemiological reports misrepresent the population in the data leaving their health status hidden (Polednak 1989). Epidemiological studies often report data inaccurately (Polednak 1989). For example, a quick glance at table 2.1 shows cardiovascular disease and cancers are the major problems for blacks. Polednak explains this is misleading. Another problem Polednak (1989) identifies in his study is how data gets reported inaccurately, especially in the final count. Polednak (1989) feels this colors the picture of the population.

The Institute of Medicine (2002) report, a comprehensive document focuses on the relationship between the political economy of health (Smedley, Stith and Nelson 2002). This work captures the way poverty, a lack of social support, and lack of access to resources creates a dangerous situation for minorities (Gotay and Wilson 1998). Poor health status of blacks is connected to the socially deficient position created, identified and defined by controlled political and economic conditions. Blacks' health is threatened by poor housing, education,

and employment opportunities. Historically, blacks have been denied access to quality care (Dennis 1999). Epidemiological reports show biological factors and give extensive explanations about social inequalities, still the degree to which white privileging and black burdens bridge a gap in health is difficult to capture in quantitative or biological reports. Further data must be included. Most important the level of sickness, does not determine where institutions to treat the sick or technology to treat particular populations is provided. There is no evidence biological factors define technology, treatment, or facilities. The power for development of care is based on political factors.

Socioeconomic Factors

“Race and ethnicity are powerful predictors of health-related outcomes” Nickens (1996). They are markers at every level of the health care system. Smith’s (1995) description of the need for the development of a black public health system gives a historical account of poor social conditions among for blacks that obviously had a long term affect on blacks overall health conditions. Another example of how race and ethnicity affects health is found in the anthropologists association between status, roles and positioning in society as major influences in the construction of sickness (Hahn 1995, Dressler 1995, Bear 1992, Gary 1996).

Specifically, being positioned at the lower-echelons in the hierarchy of employment, education and care, African Americans are less likely to be insured than members of other groups. According to a study, by the MDX Health Digest published on March 20, 2000 a 60 percent reduction in the gap in mortality rates could occur with improvements in education and treatment if:

- Fewer blacks live below the poverty line. A higher number of blacks (33%) lived below the poverty line in 2000 than whites (12%).
- More blacks are insured. Fewer low-income workers have insurance or are eligible for free services.
- Blacks had fewer social stressors. Blacks have behaviors that lead to increased risks of other diseases, such as needle sharing or unsafe sex, affected by alcoholism, stress and so forth.
- Blacks have problems with physical activity. Cultural differences in exercise and beliefs affect blacks.

Other research showing how socioeconomic factors reveal African

American women are more likely than others to experience stressors related to poverty, violence and racial discrimination (Danigelis et al. 1996). Regarding medical treatment for women in poverty on black women they are less likely to have access to primary care physicians and are more likely to receive care in hospital outpatient clinics, emergency rooms and public health sites than other women (Daly 2000).

Overall, there is a correlation between the construction of sickness and social position as evidenced in the treatment of poor black women in America (Salk et al. 1992). The study conducted by Salk et al. (1992) shows poor women and women of color receive more abusive and damaging care than other women receive. Their work also shows these women are more likely to be used for experimentation. This work goes on to explain why blacks are less likely to get treatment using state-of-the art technology. The explanation is that their socioeconomic status prevents them from being afforded this optimal treatment. This relates back to the MDX report showing more blacks live in poverty than

whites, blacks are also less likely to be insured blacks are less likely to receive equal treatment.

In the past, the system blamed the victim (Salk et al. 1992). There is overwhelming evidence that the severity of disparities in health care is not restricted to the patient. This is connected to treatment process (Salk et al. 1992, Byrd and Clayton 2000, Clayton and Byrd 2001, Harrison 1999). The Institute of Medicine puts the problem into perspective by identifying unequal treatment as the problem. It is pointed out among these researchers that health care treatment received by blacks across every socioeconomic and educational level is inadequate in comparison to treatment received by whites (Clayton and Byrd 2001, Byrd and Clayton 2001, Dennis 1999).

Messing (1998) study among hospital workers shows they work in a place where blacks are unfairly treated. The report shows even women who work in lower-paying occupations are at greater risk for exposure to contaminants. Blacks working in environmentally inferior positions that is, hospital cleaning increased the level of vulnerability than other workers (Messing 1998). In another study (Clark 1998) that compared Mexican American and Anglo health care workers, it was determined that distribution of health-related work was directed according to gender. Black women are treated as though they are of lesser value than black men or whites or either gender.

In both of these studies black women are also regarded as invisible. The level of vulnerability to disease and infection as a result of being regarded as invisible is rarely considered. Value is placed on the individuals based on

socioeconomic status, gender, and race. The social position determines how near or far away blacks will be contamination or disease. This is based on political factors. Blacks are commonly treated as invisible as recorded in the literature. Examples found in literature on discrimination and racism by St Jean and Feagin (1998), Feagin and Sikes (1994) include experiences where blacks conveniently were ignored in stores or in business.

Political Factors

It is important to examine the psychosociological situation of the population being studied, but it is also necessary to identify which political forces control the behaviors. Harrison (2001) believes the overall problem is that blacks experience in health care is limited. Blacks especially have inadequate control and limited input into the development of the infrastructure in their own community (Dennis 1999). Attention is given to the argument that the lack of control of the infrastructures in the community. Education is targeted here noting a reduction in the number of federal scholarship programs for black medical students resulting in a decrease in the number of black doctors trained over the last 15 years.

A reduction in the number of federal scholarship programs for black medical students occurred resulted in a decrease in the number of black physicians trained during the last 15 years. This reduction in scholarships restricts blacks (Dennis 1999). In Dennis' (1999) view, this is a denial of the opportunity for blacks to provide or receive adequate care. The overall impact is devastating because black doctors treat more black patients than white doctors. This means black patients are less likely to get optimal care because offering doctors will have less time to provide health care.

The literature shows providers; offer different treatment under different conditions based on race. White patients receive more care [time allocation] because of the ratio of doctor to patient (Dennis 1999). Unfortunately, black doctors do not have the same advantages. They treat patients under the same conditions as white doctors. Black doctors do not receive the same insurance reimbursements nor do they have the same hospital privileges (Dennis 1999). Even in these modern times, black doctors are expected to treat patients with their hands tied (Dennis 1999). At the same time they have more black patients who are sicker with was insurance. Black doctors' experience fewer insurance reimbursements and do not have the same hospital privileges (Dennis 1999). It is evident a difference in power and control exists for black providers. With these types of constraints placed upon providers it makes it difficult to extend optimal care for patients. Most unfortunate is that even when patients encounter black doctors, the doctors are saddled with their own burdens. It is reiterated.

Black doctors according to the report often:

- have the sickest patients
- must operate under the poorest conditions with limited resources
- must fight for equal access to insurance reimbursement
- lack of support from their white colleagues
- receive little support from their parent organization, the American Medical Association
- have more patients than their white colleagues because they take patients their colleagues will not treat.

Further obstructing progress in the situation is the resistance in the medical society to discuss race as a cultural construct (Perkoff 1997).

The results of not being able to receive optimal care are that blacks suffer disproportionately from:

- a difference in cholesterol levels from whites
- increased risk for tuberculosis
- increased risk of hypertension
- a lack of preventative care
- cultural differences, such as diets, exercise and smoking (Dennis 1999)

Perceptions of Health–Trust and Satisfaction

This is critical in the level of analysis. One way to explain this level is to use breast cancer as an example. Erwin et al. (1996) study of 221 women in rural Arkansas found breast cancer is a disease not commonly discussed in the African American community. In fact, fear and stigmas attached to the disease instills the “No Talk” rule practiced by African American women in that community (Erwin et al. 1996, Erwin 1999). Women believe a diagnosis of breast cancer is a death sentence (Wardlow and Curry 1996). The combination of the “No Talk” rule and the fear of a diagnosis that may lead to a death sentence keep women at a disadvantage.

Thematic implications in the literature suggest black women are:

- not exposed to breast information
- unaware of the significance of early screening and detection
- fail to understand the importance early treatment for breast cancer.

Anthropologists show lack of trust is the major barrier to health care for black women (Erwin et al 1996, Barbee 1994, Gary 1996, Jeffers 2001, Mathews et al. 1994). Until now it has been one thing to say that black women who present late for screening and treatment (Burnett et al. 1995). What still needs to be

examined are the existential circumstances contributing to the lack of trust women have in the information they obtain about disease.

Houkje Ross (2000) indicated in an Office of Minority Health Report, that a study conducted with Vietnamese women at the University of California shows women have trust issues. The study reports an increase from 25 percent participation for cervical cancer screening to 78 percent of the number of women participating after offering culturally sensitive intervention programs. The Vietnamese women listed five major reasons for the lack of participation. They had:

- feelings of shame. Women believed if they participated in cervical screenings they were sexually active.
- age as a deterrent. Older women did not feel they needed screening.
- a need for confidentiality was important. The small intimate community meant patients knew their doctors. That was considered a barrier because the women did not want to disrobe for the doctors.
- Vietnamese doctors who relied on traditional knowledge did not advocate pap smears for their patients.
- strong feelings about the important status of their socioeconomic status.
- Because the women were poor there was the fear that another problem may evolve.

Although culture was considered to the extent that a Vietnamese doctor was recruited, other factors proved to be equally as important to the patient. This shows that perception of sexuality, age, confidentiality and embodiment of exposure may be different in other cultures from the western beliefs. However, much like African American women trust is a major issue of concern.

Rather than understand how the fears or myths are formulated, scientists can become too eager to change the behaviors of the population being studied. Medical models (for example, the health belief model, Explanatory Model) from the dominant culture are used as the basis for teaching appropriate behaviors.

Too assimilation or acculturation is expected without full understanding of the traditional or folk practices (Dennis 1999). Ignoring the cultural or traditional behaviors only exacerbates fears. This further limits blacks experiences in the health field and perpetuating power and control. Dennis' (1999) work points out how these limitations leaves the population little to identify with in the biomedical world.

During segregation in America blacks were denied: access to the more advanced technology, adequate treatment for curable diseases, basically choices (Bailey 2000, Byrd and Clayton 2001, Byman 1991). This created the feelings of fear that they will receive poor health care. Sealing these feelings was the Tuskegee Experiment in which 399 men were told they wee being treated for syphilis when they were only being observed (Byman 1991). To date there is no mention of a study or any work on the women who were their partners. These actions set precedence for trust between women and the system. These are examples of segregation and discrimination, which are direct components of political economy major contributors to the disparity in health (Byrd and Clayton 2000, Clayton and Byrd 2001).

Racial Disparities and Education

Farmer's (1998) work shows resistance to disease is connected to distribution of information. Farmer's finding also shows that for two infectious

diseases, tuberculosis and HIV/AIDS inaccurate information distributed about and among minorities influenced the incidence rates. Tuberculosis reemerged during the last few decades but was not identified as a major health problem especially in poor communities (Farmer 1998). The HIV virus was misrepresented initially as a Haitian disease (Farmer 1998). Culturally competent literature and training for providers is perceived to be one way to prevent this misrepresentation from continued.

Production of culturally competent programs implies a necessary power shift. The Erwin et al. (1999) study as well as the Mathews (2000) study proved African American women experience cultural conflict with presentation of materials. Historically anthropological studies focused on folk and traditional medicines, identifying ways to divide natural from unnatural causes of sickness, illness and disease in indigenous populations (Snow 1974, Kleinman 1978, 1980). Cures through spirit-filled means with conjurers, root doctors, and religions place emphasis on the ritual (Snow 1974, 1976). Rarely are issues of racism addressed in folk studies nor is behavioral changes encouraged in studies on traditional medicine unless it is life threatening or unethical.

In more recent studies such as Erwin's et al. (1996, 1999) study, on breast cancer education strategic approaches to educate women proved to be efficacious. Testimony is used to educate black women. This does not mandate change in behavior.

In Erwin et al (1996, 1999) study they show how important it is to meet the population where they are in order to help them move forward. The intentions

were to help African American women age 40 to 70 across all socioeconomic groups use a familiar strategy to help address their daily challenges so they can become a patient.

Erwin et al. (1996,1999) parallels others showing the untiring need for a connection with a higher power among this population. A number of other researchers have documented the relationship between prayer and breast cancer (Jennings 1997, Mathews 1994, Pergament 1990). The connection may be as Phillips et al. (1999) found that African American women have a fear of fatalism so great for breast cancer that only prayer can help?.

The conflict lies within the expectations placed upon the women in educational programs. Black women feel educational programs are directed toward white women (Mathews 2000, Erwin 1996) as the women with the highest incidence rate (American Cancer Society 2001). Yet expectations in the health sector are that black women will respond with the same fervor as white women (Olsen and Frank-Stromberg 1994).

Here it is important to move away from general educational programs into the area of technology to make a point about expectations of this group. The Institute of Medicine Report (2002) shows the outcome for blacks and whites for major medical procedures is not the same. Then it is realistic to have the same expectations of the two groups? The improvement in education and technology for breast cancer helped reduce mortality rates through early detection (Michalski and Nattinger 1997, Nattinger et al 1992, Lannin et al 2002). The gap in use of mammography has narrowed so that between 60 and 70% of both black and

white women uses mammography (Lannin et al 2002). Still the mortality rate for blacks decreased at a slower rate than for whites (American Cancer Society 2001). The focus shifts back to where to exert energy. Thus far attention is placed on teaching blacks to improve upon their behavior, rather than empowering blacks.

There is evidence that patient/provider relationships shape the link between technology and disease. Technological advancements are intended to enhance or alter interactions between the disease process, individuals and their environments (McElroy and Townsend, Brown 1996). The Institute of Medicine Report (2002) shows African Americans are less likely to be put on the evaluation list for transplants than whites for kidney and heart transplants. This is disturbing when it is considered that blacks have a higher renal failure rate between blacks than whites (Smedley, Stith and Nelson 2002). This is relative to diabetes and other conditions. Among women, only 50.5 percent of African American women versus 70.7 percent are referred for evaluation and 53.9 percent African American men versus 72.2 percent of white men (Smedley, Stith and Nelson 2002). The Institute of Medicine (Smedley, Stith and Nelson 2002) report shows a study conducted by Alexander and Sehgal (1998) found African Americans are less interested in receiving transplants than whites. I argue that "less interested" implies apathy rather than showing cultural concerns connected to transplants.⁵ Improvement in education and treatment for both patients and providers would probably change the "less interested" feelings.

⁵ The suggestion of cutting into the body has connotations. Mutilations as a result of the harsh treatments during slavery and desegregation are etched in the memories of blacks. This

Segregation and discrimination contaminated the sickness experience influencing perceptions about transplants. Byrd and Clayton (2001) study shows historically blacks received harsh treatments involving what was considered mutilation (Savitt 1978) as a result of social inequalities. I would argue segregation, discrimination, prejudice, stereotype, racism, and sexism compromise evidence that can be presented showing that transplants are advantageous. Educational attempts must inform African Americans and their providers about all the risk factors (Olsen 1994, Mohrmann et al. 2000, Jennings 1997).

Physiological Disparities Among The Races

Thus far I have shown how socioeconomic, political, economic and behavioral factors impact health disparities. Next physiological variations are discussed for specific illness. Fife (1995) explains the meaning of illness as a cognitive phenomenon from a specific event or situation that requires a social adjustment. This point is blacks have not been afforded the opportunity to make appropriate social adjustments for the severity of their illness. They have poor socioeconomic positioning. Power and control used to draw lines, destroy trust and disable blacks had a grave impact on their physical health.

Racial disparities remain problematic in the health care system. The frequency of patterns of disease are evaluated and often connected to biological factors by governing agencies for example, the American Medical Society, the National Institutes of Health, the United States Government Center for Disease

Control. These agencies determine the health status of the nation. Social scientists reviewing health data point to socioeconomic factors as limitations, stressing the need for lifestyle improvements. Byrd and Clayton (2000) cite unequal treatment as the major reason African American women between the ages of 40 and 70 have higher mortality rates than women of other ethnic descents for many of the major diseases. They identify with a myriad of issues, those already mentioned as well as other political and economic factors. Clearly a theoretical paradigm has not been able to capture all the factors contributing to the disparities in health care between the races. It is difficult to assess why certain groups suffer disproportionately.

The difference in disease patterns requires not only looking at how disease is distributed but how resistance to disease is portrayed in the dominant culture. Ecological anthropologists offer a suggestion that is a viable starting point: look at not only how a disease is distributed but also how resistance to disease is portrayed. McElroy and Townsend (1996) show resistance to disease develops in three ways:

- Through passive resistance given by the mother
- Through active immune response from exposure to the disease
- Through genetically inherited traits.

The following information compares four of the six diseases identified “as deadly” among minority population. Portrayal of the disease patterns affecting adults is discussed to show that resistance to disease is influenced by both political and economic factors.

Cardiovascular Disease

Cardiovascular disease (CVD) heart disease continues to be the leading cause of death among all racial/ethnic groups (Minino et al. 2002). However, National Institutes of Health reports show that as whites become healthier decreasing their mortality rate by 20 percent over the last two decades. In comparison, the overall decrease in mortality rate for blacks only decreased by 13 percent at the end of the 20th century (Minino et al. 2002). In fact, looking at the population according to gender, black men die at a higher rate than others from heart disease (National Institutes of Health 2002).

The major difference is in the distribution of risk factors. A comparison of risk factors reveals more blacks have risk factors for CVD at earlier ages than whites (Minino et al. 2002). National Institutes of Health list the following risk factors for CVD:

- high blood pressure
- 2) high blood cholesterol
- cigarette smoking
- excessive body weight
- physical inactivity

According to the MDX report mentioned earlier in this chapter blacks have more risk factors associated with heart disease. Thirty-five percent of black women ages 20 to 74 have hypertension compared to only 25 percent of white men (National Institutes of Health 2002), The second leading ethnic groups with hypertension is Mexican Americans (National Institutes of Health 2002). In the last two years, limited data has been collected for screening cholesterol among other minority populations. Fewer than 50 percent of American Indian/Alaska

Natives, 44 percent of Asian Americans and 38 percent of Mexican Americans have been screened.

HIV/AIDS

The HIV virus, which may develop into AIDS, is the third leading cause of death among the black population. Hispanic males age 25 to 45 shares the burden of disease with African American males. Among African American males age 25 and older, HIV/AIDS is the leading cause of death. Hispanic and African American men accounted for two-thirds of the total cases in 1998 (American Medical Association 2002).

To demonstrate resistance to the disease information about a study among pregnant women is provided. McElroy and Townsend (1996) completed a study showing a passive resistance to HIV/AIDS among newborns in 65 to 75 percent of the cases of pregnant mothers; the infant is born healthy without the virus. This shows it is possible for genetic factors to occur to increase resistance to the disease. Polednak's (1989) recognized an interconnection between outcomes and the individual's environment. He states irresponsibility, is a part of some minorities' social behaviors. Specifically he found needle sharing and unsafe sex to be major contributing factors for the high HIV/AIDS incidence rates among minority populations.. In Quincy, Florida sex for small amounts of money for nails was one of the social behaviors identified in the an article in Essence magazine (2003). This points to how information influences perceptions about disease (Polednak 1989). Certain statements give a full profile of the disease as well as the character of the sufferer (Salk et al. 1992). Put another way, the social position of the sufferer is written into the statement.

Diabetes

Diabetes is the fifth leading cause of death among African Americans. The rates for African Americans are twice that of whites (Clayton and Byrd 2001). Death rates for the disease have increased from 20.1 to 28.5 during the last two decades for African Americans. In addition the black/white differential rate continues to increase each year from 133.7% higher than whites to 143.6% higher than whites. Clayton and Byrd found that only limited research has been performed on minorities and factors influencing the disease.

Risk factors for the disease include:

- hypertension
- high cholesterol
- obesity and
- lack of physical activity.

This is a widely researched disease that is literally crippling the black community. A literature search on Pub Med using keywords diabetes resulted in more than 180,000 articles found on diabetes alone. Blacks are among the research because when blacks are added 2,259 articles were found. An additional 3, 820 articles are listed on high cholesterol. Reports show factors that can improve the health status of individuals with the disease include control of diet and exercise (Yang et al 2002, Kohler 2000). An advanced search of the literature did not explain why only 187 articles were found about diabetes, blacks and obesity or why the number fell to 22 articles when exercise was added.

Several reports focused on minorities and diabetes including, the Malone Heckler Report and Institute of Medicine report.. These reports alerted the health community that more than half of the black female population (53%) is

overweight compared to a little more than a third (34%) of white women (National Institutes of Health 2002). The disparity in health between the races are attributed to African Americans suffering from inadequate physical activity more often than the general population who reportedly meet only the minimum recommended time required for leisure 22 percent of the time (Coday et al. 2002).

Studies show that biological problems are influenced by structural barriers, such as lack of social support, limited access to transportation, poor housing, risk of violence as a result of poverty (Izquierdo- Porrera et al 2002, Rimmer et al. 2002, Duppert 2002). In addition minorities are faced with problems as a result of acculturation. Rittenbaugh and Goodby (1998) compared lifestyles of Native Americans in the United States who had diabetes, by analyzing diets and labor saving devices in the homes with physical activity and obesity rates. They found not only did acculturation affect cultural beliefs, but it also impacted the health status of the population by decreasing the level of daily exercise. When they changed the way they performed their daily tasks, they decreased the amount of walking lifting and bending they did on a regular basis, lowering the level of activity. This was not considered exercise before the researchers performed the study.

Cancer

Of all the diseases cancer is one of the nation's more serious health problems. It continues to kill more people of all racial and ethnic groups than AIDS, accidents, and homicide combined (American Cancer Society 2000). Cancer is a disease that results in high mortality rates among minorities. Mortality

rates for blacks remain higher than whites. The American Medical Association (2002) reports African Americans have a cancer death rate that is 35 percent higher than whites.

Studies show more men contract the disease than women. Fifty percent of all men will get cancer compared to only 40 percent of women who will get cancer over a lifetime. In addition, mortality rates for black men are 50 percent higher than white men (American Cancer Society 2001). It is disturbing to see black men have a mortality rate of 226.8 versus 151.8 per 100,000 for white men (American Cancer Society 2001).

According to the National Institutes of Health Reports for specific cancers, black men have a higher mortality rate from lung cancer (49.9 versus 39.3 per 100,000) than white men. The death rate for prostate cancer is 55.5 for black men versus 23.8 per 100,000 for white men (National Institutes of Health 2000). Higher rates are also recorded for lung cancer among black women 110.7 versus 72.6 per 100,000.

Among other minority groups, colon and rectal cancers are seen more often in Alaska native men and women than whites. Native Hawaiians have higher incidence rates for lunch cancer than whites and Vietnamese women have higher incidence rates for cervical cancer than white women (National Institutes of Health 2001). Lastly, African American women have a higher mortality rate for breast cancer despite a lower incidence rate (American Cancer Society 2001). If the overall picture of the health of Americans is considered whites are considerably healthier than all others.

Women appear to be sicker than men for certain cancers. Recorded mortality rate for lung cancer among black women 110.7 per 100,000 are higher than those of white women at 72.6 per 100,000) (American Cancer Society 2002). Among other minority groups, colon and rectal cancer is seen more often in Alaska native men and women than whites. Native Hawaiians have higher incidence rates for lung cancer than whites and Vietnamese women have higher incidence rates for cervical cancer than white women (National Institutes of Health 2001). African American women also have a higher mortality rate for breast cancer despite a lower incidence rate.

Breast Cancer

Studies show breast cancer is a major concern in the United States since 1 in 9 women has a chance of developing the disease over a lifetime. For African this is misleading. Epidemiological studies reveal African American women have a lower incidence rate but they have a higher mortality rate than other women for the disease (see Figure 2.1). In fact, mortality rates of white women showed a decline during the 1990's however other ethnic groups did not have the same experience. African American women experienced a decline in the mortality rate between 1997 and 1999 (National Cancer Institute 2001). African American women believe the disparities are interconnected to their social positioning, cultural beliefs and the overall political economy of health (Mwaria 2001, hooks 1981, Davis 1981).

In 1997 cancer was the second leading cause of total deaths among African Americans (22.2%) surpassed only by heart disease (27.9%) (see Table 2.1) (American Cancer Society 2000). The message in the mainstream literature is

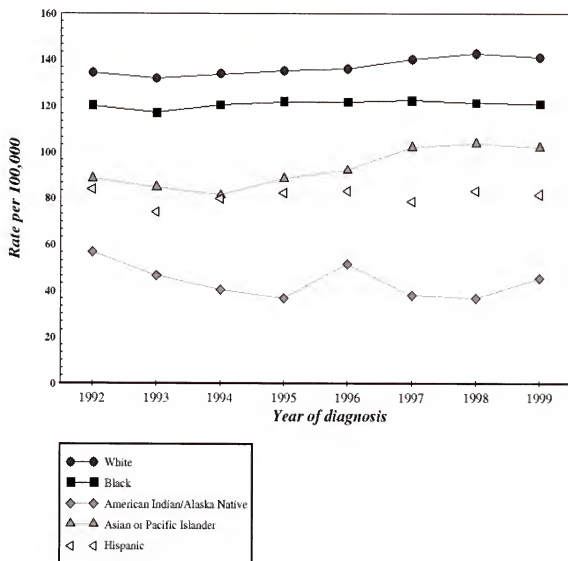
perceived to be clear: early detection of breast cancer can save lives. Breast cancer is nearly 97 percent treatable when detected early (American Cancer Society 2000). A plethora of literature (Mathews 2000, Erwin et al. 2000, Bailey et Erwin 2000, Briton et al. 1997, Cheverly et al. 1997, Mathews et al. 1998, Chang et al. 1996, Mickey et al. 1995, Douglas 1995) indicates that early detection is the key to survival for breast cancer. Many researchers are now examining even further how variations in cultural beliefs, attitudes and knowledge affect health care practices (Zhu 2000, Erwin 1999, Jeffers 2002, 1998, Hughes-Gaston and Porter 2000).

Threat of Breast Cancer

Epidemiologists show the incidence of breast cancer varies between black and white women with African Americans being slightly more likely than white women to develop breast cancer before age 45, and slightly less likely to develop breast cancer after age 50 (see Table 2.2).

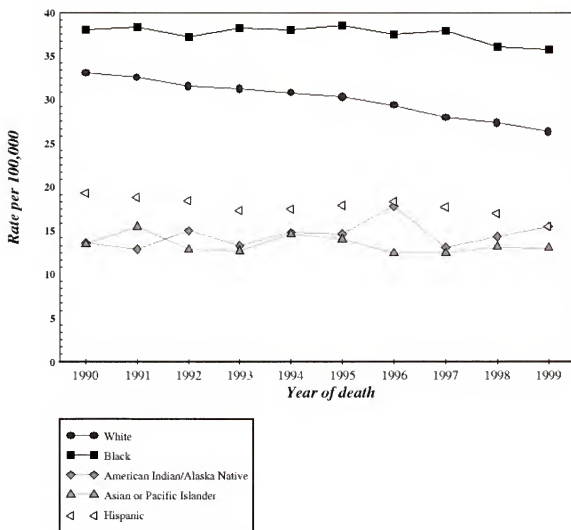
It is important to recognize that for all women, the profundity of a diagnosis of breast cancer is difficult to articulate because of the assault on both the maternal and feminine roles. Nettle-Carlson (1996) and Manderson (1999) indicate that women worry about their breast differently than they worry about other parts of their bodies for two reasons. First, the breast represents sexuality and secondly femininity is expressed in the breast. Overall a major problem for African American is late stage diagnosis. a higher percentage of African American women present late at every stage according to the American Cancer Society (see figure 2.4). Is the problem a lack of awareness of breast cancer or is

it time to examine existential circumstances affecting the African American woman's ability to obtain care?



Source: National Cancer Institute Surveillance Epidemiology and End Results (SEER)- Rates are expressed per 100,000

Figure 2.2 SEER Incidence Age-Adjusted Rates, 11 Registries, 1992-1999



Source: National Cancer Institute Surveillance Epidemiology and End Results (SEER)- Rates are expressed per 100,000

Figure 2.3 U.S. Mortality Age-Adjusted Rates, Total U.S., 1990-1999

Table 2.2 Chances of Developing Breast Cancer for African American Women.

Age	African American	Nationwide	European American
30-34	33.3	12.6	23.6
40-44	123.9	60.3	119.5
50-54	236.4	129.1	260.2
60-64	297.0	184.3	366.1
70-74	378.2	263.5	483.3
80-84	362.5	304.1	490.9

Rates are per 100,000

**The above information was taken from SEER data and can be found at
Source: www.seer.ims.nci.nih.gov/

A look at trends shows several factors influenced the change in trends for breast cancer. Social changes influenced the changes in the trends for breast cancer. At the same time changes in the epidemiology of cancer occurred, social, economic and political changes occurred for women in America.

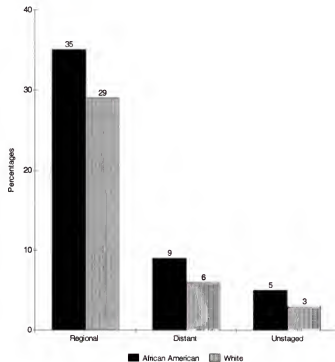
From early in the 20th century to near the end of the 20th century, breast cancer according to the American Cancer Society, the disease has gone through three distinct phases:

Phase I	1940-1982	Increased 1% each year
Phase II	1982-1988	Increased 4% each year
Phase III	1988-1986	Leveled

Political Economic Factors

Several political economic factors influence trends in morbidity and mortality rates. For breast cancer evidence suggests that African American women are not referred for medical procedures at the same rate as white women. Dr. Kevin Schulman of Georgetown University Medical Center shows they receive unequal treatment. Research also indicates breast conserving surgical treatment for women with early stage diagnosis of breast cancer varies according to race, socioeconomic status and geographic location (Erwin et al 1996, Chavez et al 1995, Ferrell et al 1992, Michalski et al 1996, and Nattinger 1992).

Geographical differences reported by Nattinger et al (1992) indicates breast conserving surgical treatment is used more often in women in



Source: American Cancer Society Facts and Figures 2000

Figure 2.4 Stages at Diagnosis-Comparison of Black and White Women

New England, in larger hospitals, and in higher socio-economic status than urban or southern areas where higher populations of blacks exist. In areas where higher populations of blacks exist fewer partial mastectomies are performed (Nattinger 1992). The message is breast cancer rates are more intricate than portrayed.

A close look at table 2.3 shows women must be placed on a strata to understand who is dying from the disease. Black women between the ages of 30 and 80 are more likely to die than white women from breast cancer. A 30 year old black woman is more than three times more likely to die from the disease than the average woman.

Standards for Screening

The literature states a major contributor to the disparity in mortality rates is late stage diagnosis among African American (Erwin et al 2000, Mathews et al 1996, Lanin et al 1998, Mickey et al 1995). This combined with the difference in the age of onset for breast cancer between women (Hughes-Gaston and Porter (2001) (See table 2.4) should suggest reevaluation screening techniques.

The American Cancer Society recommends women incorporate three screening techniques into their lives to ensure early detection. All women should perform monthly breast self-examinations. Women age 20-39 should have clinical breast exam by a provider every three years. Women age 40 and older should have clinical breast exams annually. Women age 40 and older should have a mammogram performed every year. Dr. Edwin T. Johnson, former surgeon questions why the incidence rates for African American women is not lower than that of white women since younger. Despite recent knowledge that African

American women have a higher incidence of breast cancer at a younger age, there are no provisions to recommend African American women for mammograms at earlier ages. When the radiology technician conducting the mammograms for the study of African American women participating in the study was asked by one of the women in the study why black women cannot have mammograms earlier her response was

“younger women have denser tissue in their breast so that readings are more difficult.”

Obviously this is the correct academic response because providers also gave this statement during different phases of the study. However, it does not answer the question why black women have to wait.

Table 2.3 Chances of Dying From Breast Cancer for African American Women

Age	African American	Nationwide	Caucasian
30-34	7.7	2.1	3.8
40-44	33.2	10.6	19.7
50-54	70.9	26.5	49.6
60-64	96.5	43.5	81.1
70-74	128.0	66.4	116.7
80-84	162.8	102.7	159.0

*Rates are per 100,000

**The above information was taken from SEER data and can be found at Source: www.seer.ims.nci.nih.gov/

In another study Ekah (2000) used screening mammography at earlier ages among black women. At Sloan-Kettering Memorial Hospital in New York City, more African Americans were diagnosed at ages 35 to 40 years as the baseline. This proved to be efficacious. Cancers were found earlier and women reported back for screening a treatment. Changing the baseline age for mammograms from 35 to 40 may be cost effective or have other benefits however it does not have good outcomes for women of African descent.

The manner by which standards are set influence the epistemology black women possess about breast cancer in a complex way. These types of structural barriers, setting standards higher or later shape cultural beliefs about how an individual approach certain diseases.

Causal relationships between biological factors combined with the lack of knowledge, high costs of health care and a lack of referrals place African American woman into special categories. The overall limited social status makes it difficult to identify which factor has the most influence on the higher mortality rate. Considering blacks have the highest mortality rates, researchers should evaluate whether or not black women should be the group that sets the standards for screening and treatment for breast cancer screening. This would mean giving black women power to decide.

Allport's (1979) extensive study of prejudice explains that race is interwoven into variables because race is often used inappropriately. Brown's work (1998) points to how race is difficult to define as a biological construct; it has more historic meaning than biological significance. Other studies show (Feagin's 2000,

Ausdale and Feagin 2001, Slocum 2001, Simmons 2001, Singer et al. 1998, Harrison 1997) work shows race is instrumental as a social construct but race is seldom linked as a causal factor. Undoubtedly race is an integral part of identity formation (Simmons 2001). Race is used for hierarchal placement of individuals on the socioracial continuum extending from white to black (Feagin 2000). In health, this is relevant because status is connected to social, economic and political positioning of individuals. Clayton and Byrd (2001:355) who were among the team of Institute of Medicine (2002) researchers credit race with being a major predictor in the poor health outcomes for African Americans. The Institute of Medicine study agrees with Byrd and Clayton's (2000) work pointing to how social, economic and political inequalities preserved an unjust gain among the individuals in the dominant culture for health while minority groups continue to experience poor.

Feagin (2000:16) calls using race to encourage the misuse of power "rich traditions", accentuating institutionalized racism. Other studies show unfair control of resources is the most efficacious way to maintain power and control (Ajani 2002, Feagin and Sikes 1994).

Conclusion

The research continues to focus on black women not being exposed to information about early screening, or their failure to understand the importance of early screening and treatment as the major contributing factor for the high mortality rate. Biological, social and political factors examined in studies indicate differences in how black women in America respond to the threat of breast cancer has racial impressions. The hegemonic effects of all of levels of power

imposed upon black women must be considered in order to make an adequate assessment of the epidemiology of breast cancer. The point that is made in this chapter is profiling is intentional and has a purpose. The way the health status of blacks has been compromised is consistent and has a rational pattern. This points to a greater level of awareness of a culture of resistance. This culture of resistance is based on distressful external factors. It is important to recognize that many interventions [Tuskegee] that blacks historically participated [Tuskegee] in used radical means for treatment. These harsh treatments perpetuated fatalistic ideas blacks may have about treatment for disease. Based on the data presented in this chapter, evidence that blacks are not inside the power structure, it should not be surprising that black women feel the odds are stacked against them for breast cancer.

CHAPTER 3 CREATING THE PROFILE

Introduction

The structure of health services is designed to treat patients according to the severity of the sickness, illness and disease. The history on equity of care documents unequal treatment between the races. Research indicates differences in access to care and health behaviors may be attributed to certain elements about ethnicity such as status. Anthropologists attempt to understand how gender roles shape health beliefs among minority women (Chavez et al. 1995, Mathews et al. 1994, Mathews 2000, Erwin et al. 1996, 1999). Findings show contradictory cultures caused cognitive dissonance among women (Mathews 2000). Hispanic women believe one cause of cancer is external factors [blows to the breast] Chavez et al 1995). African American women have a conflict in the conceptualization of survivorship (Mathews 2000). Also, educational programs do not meet the needs of African American women (Erwin et al. 1996). These researchers recognize the need for a shared cultural consensus to help empower minority women so they can better access the health care system.

These findings are evidence that focus is moving beyond a lack of knowledge among the women into concerns about the embodiment of femininity. Some researchers point to a shared construction of the disease breast cancer (Lannin et al 2002, Moore 2001, and Mathews 2000) as the baseline for the investigative studies. Others feel the concept of the disease must be interpreted

in relation to culture as well as the embodiment of femininity (Singer and Baer 1995, Hahn 1995, Manderson 1999). Black women have a complex conceptualization of breast cancer in relation to survivorship (Mathews 2000). The question to answer in this chapter is, how and what do black women learn about certain breast cancer?

In order to respond to this question the creation of gender role expectations of the black woman from entry into the New World through treatment as a patient is discussed in this chapter. An attempt is made to connect power, establishment of gender roles of black women and patient roles.

First black women are located in the history of the nation. Next, the symbolic, cultural and social construction of the black female role is discussed. A historical account of the construction of these roles shows power and domination existed in each position. A final account of how profiles affected black women is given in a review of the early treatment of black women as patients. The intentions are to show that these profiles remain in the psyche of patients and providers.

How Did We Get Here

A discourse on the historical perspective of the health or sickness and disease of blacks in America oftentimes begins with emphasis on the loss of life during the shipment of people from the continent (Table 3.2). Limited historical accounts are given about the medical deprivation of between 10 and 20 million Africans displaced during enslavement who survived the slave trade (Byrd and Clayton 2000: 85). Not only were fifty to one hundred million black Africans disenfranchised when they were sacrificed to the institution of slavery but their

health status was compromised for generations beginning with the time of being captured (Byrd and Clayton 2000).

Table 3.1 Slaves Losses in Transit 1715 to 1175
Losses Sustained by the Slave Traders of Nantes

Period	Mortality from Disease (%)	Mortality from All Causes (%)
1715-19	12.2	19.1
1720-24	19.1	22.4
1725-31	13.5	13.5
1732-36	18.4	18.4
1737-41	19.4	19.6
1742-45	11.1	16.8
1746-50	10.8	11.5
1751-55	15.8	15.8
1756-63	5.9	7.9
1764-68	13.2	13.2
1769-73	14.2	14.8
1774-75	5.3	8.6
Mean 1715-55	14.5	16.2

Note: Nantes was a major French slave port. Table records mortality rates during Middle Passage for 40 years. The Mean mortality rate was 16.2 for all causes.

Source: Byrd and Clayton (2000)

The significance of painting a historical portrait of black women in America is that we apply health beliefs and practices according to how we perceive ourselves as patients (Hahn 1995). African American women are dying from breast cancer because something keeps them away from obtaining medical treatment. They do not discuss the disease (Erwin et al. 1996). The sickness experience is influenced by one's personal attitudes and beliefs about the expectations of what one should do and how an individual should behave (Burnet

et al. 1995 Hahn, 1995, Mickey et al. 1994, Powe et al. 1995, Robinson et al. 1991, Smyth and Yarandi 1996).

Historically, there were conflicting beliefs about the cause and treatment of sickness. Prior, to the 20th century when the poor became ill it was regarded as God's will for the person to be sick (Dubos 1993). Now, there is evidence that knowledge of sickness and illness is socially determined (Young 1982). The inhumane treatment of slaves was rooted in a combination of Christianity, economics and science. Science moved from mythical to the mathematical, natural scientists placed humans in a hierarchical chain (Molnar 1992). Other scientists using the empirical approach, Josiah Clark Nott and Samuel A. Cartwright also placed blacks in a subhuman position especially for medical treatment according to Savitt (1978). The point is that classification of blacks and sickness were both decided by natural scientist.

Establishment of Slave Roles

Aldridge (1991) believes understanding the social history of women requires reflecting upon "the fundamental institutions upon which America" was built. Wilson and Russell (1996) report that European women were brought to the New World as early as 1511 to replace depleted workers. Drake's (1990) records show slaves entered as early as the 14th century. Discrepancies in the dates of arrival should not distract from the focus, the fate of those who came into the country unwillingly.

Consistent in the literature is the fact that when slavery was being enacted, new social relations were created. Kinships in Africa were destroyed without being reinstated in the new environment. Kinships are important because they

explain how group membership is structured. Group membership defines status, roles and positions in kinships (Tylor 1998). Women of African descent who were introduced to a conflicting culture had their native group membership erased by slavery.

From the time it was discovered that one human was possibly weaker than another, slavery existed (Johnson et al. 1988). The difference was that power was not always used to give the slave owner the right to determine life and death over his slaves (Johnson et al. 1988). This is largely because ownership of slaves was merely a status symbol before enslavement in the New World. Asante, the dominant ethnic group in West Africa, in the 17th century, who fought the British over slavery for nearly a century, practiced slavery as early as the 15th century. Still, they allowed slaves to maintain families, own land, produce crop, and own slaves themselves (Johnson et al. 1998). Thus, they were not alienated from human existence as blacks and women were in America.

The shared experience of slavery for the colonizers and slaves was influenced by the belief of Europeans that God gave them the "right" to provide civilization to a primitive population, therefore they Americanized slavery (Blassingame 1977, Harris 1968). In fact, it was considered essential and appropriate to mistreat slaves in order to convert the sinners who were captured into Christianity (Harris 1968). This way enslaved persons could be taught appropriate roles (Hines and Thomas 1998). This permanently changed the roles of blacks and women. They were identified first as the, "others."

Slavery was considered an economic investment. Development of the status of “the other” allowed the black body to put at the center of the material social process as an integral part of the infrastructure, as a form of production.

Identifying New Groups

Black and white women were brought into the country initially as a form of punishment (Wilson and Russell 1996, Hines and Thompson 1998, Blassingame 1997, Drake 1990). Considered first to arrive, white women were brought into the country to become wives for the Spaniards and prevent miscegenation with Native Americans (Drake 1990). Miscegenation, for the purpose of this work means to contaminate white blood. They were unsuccessful in preventing miscegenation which occurred among: Native Americans and whites; whites and blacks; and blacks and Native Americans (Hines and Thompson, 1998, Wilson and Russell 1996)..

During the early colonization both black and white women were indentured slaves. According to Wilson and Russell (1996) white women who were labeled, prostitutes and religious dissidents were taken off the streets of places like London and sentenced to indentured servitude. The structure of families for both black and white women was destroyed when women were removed from their native habitats.

However, a promise for white women that one day they could buy their freedom was upheld thereby giving them a fixed position in society. White women went on to advance and emerge from being enslaved to a position below the white male but above the black woman (Wilson and Russell 1996). Historians point to the fact that black women who were also indentured slaves were less

likely to obtain freedom especially as the value of blacks was realized (Russell et al. 1992, Wilson and Russell 1996, Hines and Thompson 1998, Blassingame 1999, Bennett 1975). From a political economic perspective social relations to resources and power now differed between white and black women.

Records show from the 17th through 20th century's racism and sexism were enacted as the dominant ideologies to shape relations of production, economic structure of society, and social roles (Russell et al. 1992, Wilson and Russell 1996, Blassingame 1999). Gender roles, the culturally constructed roles of men and women were altered structurally to accommodate historical situations (Harding 1994).

The Denial of Presence

One major effect this had on women is that it separated black women by denying them presence. Blacks were not familiar with the beliefs, laws, morals and customs that made up the dominant culture. Blacks did not know the language, the value system, or the belief system, the components of culture as defined by cultural anthropologist. They were denied the right to practice their own traditions once enslaved. Roseberry's (1991) and Collins (1997) feel blacks were severed from their kin, kidnapped, and pawned. Substantiating this is Blassingame's (1999) work showing once enslaved, valuable culturally constructed systems of knowledge and behavior formerly used by men and women of African descent were discouraged. Thus, the interrelationships between production and reproduction were established (Meillassoux 1981).

Social Construction of Gender Roles

The political economy of slavery was created to correct problems. An emotional connection to the dominant culture as being superior to others justified past and future actions (Montague 1997). Harris (1968) work on materialism shows those in the dominant society felt compelled to teach blacks appropriate roles. These are strong components of capitalism. Foucault (2000) work on power explains that what was occurring was a unity of domination. A law of power and domination was being established. Power was being enforced everywhere. The power to declare behavior of blacks as problematic to the extent exploiting blacks or even killing them if necessary for displaying traditional attitudes became acceptable. In hindsight problems caused by slavery were multiplied.

The nature of the work assigned during enslavement created a political economy that caused significant changes in status and roles among Africans. They were taken from a society where status was assured and roles clearly defined to unclear, fluid roles.. The type of status and role changes that occurred during slavery is irreversible (Blassingame 1979, Green-Powell 1999). In examining the structural hierarchy developed, it becomes clear the use of the black woman's body was a major source of labor-power, during that time.

To understand gender roles it is important to understand the work and the result of the work (Spring 1995) black women performed. Spring states that the term work should not be associated only with tangible tasks. The point to make is that the gender role for black women was specifically designed for this

population. Basically, slavery by the dominant population mentally shackled slaves and their masters into profiling blacks.

Creating Gender Differences

Gender has a special relationship with power. Snow (1993) identifies power as the ability to make things happen or change the ordinary into the unordinary. Snow continues that power is the ability to determine whether or not a state of balance will be maintained. Feminists' writers Sue Rosser and Sandra Harding declare that gender roles are more closely connected to the use of the body, power and control than biological factors.

For African American women attention needs to be diverted towards this area because her sexuality is what was exploited. In comparison to white women whose abilities are traditionally attacked (Wyatt 1994). This is brought to the forefront because this work is not a comparison between black and white women but instead an ontological approach to the issue of gender.

Several perspectives are found in the literature on gender: the symbolic construction of gender (Ortner 1974), the cultural construction of gender (Moore) and the complex social relations of gender (Barnard 2000). Other researchers (McClaurin 2001, Shaw 2001, Collins 1997, hooks 1996) argue that a black feminist's theoretic paradigm must be constructed in order to capture the contradictory discourse on the black female experience.

The symbolic construction of gender interconnects the woman with her reproductive role focusing on the fact that women give birth and men do not (Ortner 1974, Barnard 2000). One of the most profound arguments among black feminist's writers is the fact that black women were forced into giving birth and

having their progeny removed from their homes (Fox-Genovese 1988, Hines and Thompson 1998, Roberts 1997). Consequently, the symbolic construction of gender among women was permanently altered. Symbolism of the black female body in the history of America must be reconstructed.

Symbolic Construction of Gender

The symbolic construction has a different meaning for black women even using Ortner's (1974) theory. Ortner's model explains women's subordination is due to their close connection with nature. Her statement is that women are closer to nature; they even symbolize nature as evidenced by their ability to reproduce. Conversely, men are more connected to culture and society. She does not believe this to be true but states this is how they are represented.

Unfortunately, the formulation of gender differences is fluid among black women. The original intention for servitude among white and black women was to work side-by-side, even in the fields (Johnson et al. 1998, Russell et al. 1992). However Johnson et al. (1988) study shows that in the early 17th century, white women were deemed too fragile to work the fields. Therefore, they were given less laborious task. Gibbs et al. (1980) work on nutrition examines letters written showing whites were not suited for "harsh" conditions. Ultimately, black women were prescribed distinct roles. They also became situated as "wrong" in society according to Johnson et al. (1998). They were needed for two reasons:

- the use of their bodies and
- the ability to provide another human

Black women became a major source of increased economic and political power for those in the higher positions of power. Mullins (1997) explains that

race mediated every move for the person of African descent. This is not to deny that all women suffered during this era. Wilson et al. (1992) argue that all women were stolen and brought into America to be objectified and turned into producers. Collins (1998) as a black feminist scholar points to the fact that the socialization process of women in America stratified women according to race first, then other social factors. Another researcher points to the reproductive role of the black woman calling it: work, ...birthing a baby was an expectation of black woman (Fox-Genovese 1998).

Examination of historical accounts of slavery, reveal blacks were placed in the most inferior positions, given low social status and used as a commodity (Fox-Genovese 1988, Hines and Thompson 1998, Blassingame 1979, Dubois 1985, Drake 1990). The symbolic role of the black woman was racialized. The reproductive act assigned to black women was more racially driven than socially or biologically driven. It was an act imposed upon women under the social construct of race, power and economic gain. Rosser (1989) states in her discussion on gender that to say why women are marginalized is not so simple. Yet, where women of African descent traditionally are concerned they are marginalized because of their race first and gender second.

It is no wonder Dubois (1962) in his assessment of the treatment of blacks declared that he could not find forgiveness for slavery because it is a world-old habit. He further states that, he could never forgive the world or the world to come for it's wanton, continued and persistent insulting of the black womanhood it seeks to prostitute its lust. Dubois statement captures the fact that the cultural

landscape of the tasks forced upon black women became rooted in race, power and then sex. Historical demands placed upon black women made the achievement of "ideal woman" undefinable for black women. Roberts (1997) points to how enslaved women experienced such conflicts as having to be pregnant and work in the fields. Being pregnant, diminished the time a woman can spend in the field; it decreased the likelihood for a healthy baby; and lessened the chances of her getting pregnant or carrying a child full-term. If the woman did not complete any one of these tasks it could be detrimental since black women eventually became the sole producers of the laborers (Wilson and Russell 1997).

Social theory rarely properly address how, where or why lines separate women (Collins 1997). Anthropological methodologies have difficulties addressing the issue of race. The uncertainties about race caused the discipline to avoid the subject. Further limiting the approach is the fact that ways to measure oppression, discrimination and inhumane treatment have not been developed. In relation to self-identity, hooks (1994) work emphatically states; no other group in this country had their identity erased like black women. Still, the way to measure this is difficult.

Returning to the landscape of how gender roles were shaped, from the perspective of the slave master, a major obligation of the black woman was to be a breeder. Breeding was both common and lucrative. Wyatt's (1990) research shows on larger plantations that 50 to 60 slave women were often kept solely for

white men to impregnate. Approximately, 20 to 25 children usually were born and sold (Wyatt 1997).

Under Ortner's symbolic theory, the woman gives birth to the child and maintains possession of the child. The contradiction for black women is that they were exposed to a different culture, languages, cultural beliefs, forced to bear children, stripped of their children, forced to nurture others children, and expected to have insurmountable survival skills. Moore (1988) in discussing Ortner's work refers to "a natural association" between women and children. What is natural, considering the black female experience or the symbolic construct of the black mother? Consequential to being treated poorly during the creation of the gender roles, this experience permanently impaired the self-concept of women of African descent for every generation that followed (Fox-Genovese 1988, Mama 1995).

Keller (1994) compares the complexity of the situation to being inside and outside of power. In her work on gender she parallels gender and science. She states epistemology, a "middle of the road" between the biological and social, where there is a duality that keeps the role from ever being perfect. Using this analogy and the act of rape to impregnate the black woman it is difficult perfect the role of the woman. Living with the threat of rape by those who they had to rely upon for their basic needs made a difference in how the ego-identity was formulated (McEwan 2002). Slave women betrayal and trust was violated by everyone who knew this occurred. Forcing the slave masters' power onto the woman to secure her status made the task of understanding her role difficult.

Consequently, black women were ordained to be confused about her gender role. Historical accounts show that the intentions of Western culture were never for all women to self-identify the same (Bennett 1975).

European culture ignored the fact that the predominant sex role of the African woman was the role of mother, advisor and a woman of great wisdom in her native land. These roles were gravely altered in the New World. Once enslaved, the expectations of black women changed. Black women were required to fulfill the role of producer and reproducer for their masters, to produce goods and services so their masters could become wealthier (hooks, 1990). However, they were not assured the benefit of mothering.

Production of wealth for the master often included objectification and devaluation of the African woman's body. Enough consideration is not given to the impact these bruises placed on black women's sexuality and self-identity during her enslavement. These acts of domination affected the black woman for generations, Heavy shadows implanted in the psyche of black women affected their self-identity and what they symbolized (Slocum, 2001). The black body was taken for granted leaving permanent scars on women of African descent and changing their culture.

Culture and Gender

Moore (1988) refers to culture as the relationship between kinship, economics and rituals. Kinship structure was destroyed because slavery nullified the various exchange patterns such as the descent system as well a marriage. In a study on women in Third World countries Folbre (1988) shows how gender differences were rationalized and attributed to exogenous factors. She found that

that keeping the focus on “the outside” inequalities reduced the focus on economics and political factors. This is similar to what happened to women of African descent.

Production of wealth for the master oftentimes included objectification and devaluation of the African woman's body. Moore's (1998) work shows how rituals such as marriage also influence the identity of the woman's gender role. The social science literature on family dynamics shows the black family is a complex structure. Wilson's (1998) work presents as many as 81 different variations that can be found in black families, based on differences in the current interpretations of sex roles. This is another indication that historically sex roles were deeply compromised.

Moore's (1998) work also indicates the family is one of the central places where women are oppressed. Roberts (1997) argues against the family as the place for oppression of women, stating woman of African descent place strong value upon their desire to succeed in what they consider the most important sex role; the mother. Her major reason for wanting to be successful is to gain the love of her children and family (Roberts 1997).

For example, in many African cultures, as women age, African female elders provide positive family environments to teach young girls about themselves and their responsibilities. Once enslaved as women of African descent aged, they were not always free to show their love by moving girls through developmental stages towards marriage (Wyatt 1997). Blassingame

(1979) and Wyatt (1997) give a description of one of the rites of passage ceremonies practiced in Africa but dropped once in America.

Once a young girl becomes of age, her status is celebrated. Girls at an early age are promised to their husband's family, as valuable property. A great ceremony is held on behalf of the couple, in which friends and family celebrate by giving the couple gifts to get started. The bride receives a new belt as a symbol of her rite of passage or change in status. (Wyatt 1994:17).

In America, rituals to prepare black girls to adulthood were outlawed.

Marriages were not always sanctioned (Roberts 1997), yet women were expected to reproduce. The multiplicity of a woman's identity has a direct impact on how she negotiates her way through subsystems in society, even today. Consequently, elders went from performing rituals to teaching survival techniques (Roberts 1997). The respect of the African American woman's wisdom as she aged was irreverence of her body.

Black feminists' theory points to a fragmented perception of the self. This creates problems in the negotiation of cultural values (McClaurin 2001, Collins 1990). The cognition of self-identity is interrelated to culture. This includes understanding an individual's tradition, cultures, heritage and racial identities (Oyserman and Harrison 1999). Europeans were not aware of how tied to the land Africans were in their native surroundings. Records reveal Africans were considered just cheap labor, with little regard for their expertise in agriculture (Wilson and Russell 1997). Europeans were not aware of Africans' extensive agricultural background. Hines and Thompson's (1998) work reveals that women were far more knowledgeable in the cultivation of rice than the African men or white colonists. This lack of knowledge along with other misconceptions resulted in a loss of values, attitudes and beliefs of the African heritage.

Feelings about competence and well-being were diminished as a calculated process was used to classify blacks as “inferior” as their values were shifted. This was further propagated by theological ideology that proclaimed it was fair to treat blacks this way (Harris 1968). Valuable culturally constructed systems of knowledge and behavior formerly used by women of African descent were discouraged once enslaved.

Attempts were made to preserve the dominant roles as wife and mother, a role St Jean and Feagin (1998) view as still important among black women as a sex role; however this role was also altered. As wives in their native land, they did the marketing and made clothes for their family (Russell and Wilson 1986). In addition, women did most of the weaving while the men made tools to work the fields and to hunt (Blassingame 1997). Enslaved, the work of African women was almost exclusively outside of her immediate home, with emphasis on the master’s family with little regard for their family. A major limitation for women of African descent was gender division labor, because they had the double duty of backbreaking fieldwork and then returning to their own homes late in the evening to perform household duties (Bennett 1975). They had to sew clothes, spin thread, prepare meals, wash clothes, and care for crops for their masters, then duplicate these tasks for their families (Wyatt 1997, Roberts 1997).

Roseberry (1991) examination of political economy explains, “people’s activities are conditioned by their cultural understandings.” The experience of working the fields for women, producing crops, providing sustenance for the family was not unfamiliar. What was unfamiliar was producing the goods and not

having the profit come back into the family. Working hard, experiencing pain this created an alternative epistemology even about agriculture.

Social Relations and Gender

Barnard (2000) investigates several theories finding gender is a compilation of history, power relations, and feminists' approach. It is a complex set of dynamics. Barnard suggests finding where the gender relation is anchored. In considering the mapping of the social construction of black women power and control is where the embodiment of femininity for black women is anchored. Marxist theory reports that social consciousness is couched in the relation to production.

During the development of the new culture, black women were among the least powerful; they were used as producers (Harris 1968). He approached the development of the nation from a Marxists perspective explaining that power and domination were the motivators for development of culture. Negative life experiences from the creation of separate cultural and gender specific ideologies evolved as a result of slavery although they continue to be disregarded in the literature. Scholars challenging historical accounts of the literature (Collins 1997, hooks 1996, McClaurin 2001, West 1984, Rosser 1984, Harding 1989, Feagin and Sikes 1994, St Jean and Feagin 2000) focus on the depersonalization of Black women.

Being stolen from their native land coupled with the obligation to adopt others traditional beliefs, attitudes and values forced black women to experience embodied changes. Any embodied changes according to Manderson (1999) can result in a paradox to health. A closer look at Manderson's (1999) work explains

why this occurs. Manderson (1999) approaches sickness definition by examining the relationship between social membership and body integrity stating:

- Social membership demands have control over the physical body.
- Disruptions to the body or the loss of body integrity can strip the individual of gender, sexuality [sic] and ethnicity.

Individuals who entered the country were all products of different tribes, kinships, cultural, and traditions. Generalizations imposed upon blacks caused a tremendous amount of suffering among blacks because they were being compartmentalized in an unfamiliar way. Green (1998) explains in her paper on social suffering that the phenomenology of suffering shapes how sexuality is represented. Sexuality cannot be compartmentalized. Clear definitions must be instituted. The result is that slavery was a vital part of the foundation of the political economy of America it produced a fragmented portrait of the body for those who suffered from oppressive acts.

Specifically, hard work, pain and suffering were equated with being black. Those who suffered the ultimate pain of childbirth, the meaning of being a black woman meant having her progeny taken away. Inasmuch as black women struggled to gain some form of mind-body relationship under the most austere conditions, there was also the need to establish new moral themes to survive. Black woman learned it was not always so important to be beautiful as it was to be intelligent. Being intelligent increased the likelihood for survival it also increase her suffering (hooks 1981, 1990, Wyatt 1997) In general alleged biological superiority of whites justified the maltreatment. Economic and political bias was used to maintain power and control. Karl Marx's (1844) work on political

economy explains it best stating blacks were reduced to commodities. Gender roles became complex. This justified imposing suffering upon black women at will.

There is no transcendent meaning for suffering (Engelhardt 1996). What Kubik (1999) suggest may explain how people of African descent endure such high levels of oppression. Suffering according to Kubik (1999) allows an individual to surpass ones limits. Suffering evokes the moral and the metaphysical (Engelhardt 1996).

Moral suffering is documented in the Old Testament, beginning with punishment assigned to Eve for disobeying God. Suffering occurs physically, emotionally or simultaneously. In the literature Greene's (1998) study in Guatemala on political violence shows death, hunger, chronic health problems, inadequate health care, folk illness and the use of spirituality to survive. In describing her work, she explains that the violence is so horrific that one of the ways it is embodied is through illness or attacks to the body, they are called "blood memories." Black women's gender role is anchored in suffering.

Social Construction of Sickness

The evidence shows there were diametrically opposing views of treatment used for blacks and treatment for whites (Savitt 1978, Snow 1993). Mostly, blood memories are recorded about black women who were used for improperly in the health care system. In general, they were always subjected to extremely harsh treatment. Africans suffered from the extremes in treatment, in sickness, in punishment. Africans did not have built-in immunities to many diseases and tuberculosis was a problem after being newly exposed to the communicable

disease. Yet, reasons for the disparities in the mortality rates for tuberculosis among blacks were not attributed to a lack of racial immunity. Instead, they were viewed as inferior. "Negro consumption," a severe form of tuberculosis was believed to be due to black's susceptibility and inferiority (Savitt 1978). Consequently, extreme forms of treatment were administered such as bleeding (Savitt 1979, Byrd & Clayton, 2000). Despite, having documentation showing blacks could not survive bleedings. The harshest forms of treatment were still used (Savitt, 1979).

Blacks were also used for experimentation. Savitt (1978), work indicates Dr. J. Marlong Sims experimented on black women. The surgical procedure vesicovaginal fistulas⁶ was perfected on black women. Empirical and theoretical approaches to defining health for blacks under the rubric of racism shows blacks have been and continue to be subjected to experimentation in the health care system. Savitt (1979) work shows 15 caesarean sections were performed on black women before attempting to perform them on white women. Failed attempts at experiments were blamed on blacks inability to withstand the harsh treatments. Other treatments and experiments included, unfamiliar restorative processes such as excessive use of drugs, harsh treatments, excessive bleedings or unnecessary surgeries (Savitt 1978).

Savitt (1979) work also details how a typology was established placing physicians in a position of power. Physicians reinforced the theory of inferiority among blacks treating them accordingly. Indications are that separate typologies

⁶ Vesicovaginal fistula is listed as a "communication" between the bladder and the vagina that caused urine to escape from the bladder into the vagina without going through the urethra.

were also created among blacks. Thus, blacks were forced to rely on their own skills as healers on the plantation using their own prescriptions for illness (see Table 3.2). They developed more trust in their own healers than white physicians (Savitt 1978, Fox-Genovese 1988).

Traditional healing methods were grounded in spirituality in Africa, with the philosophy of providers [overseers or physicians] was not to restore health but to place the person back in working condition to protect their investments (Harrison Bennett 1975). For blacks especially women, a new cognitive process began that altered the social reality of illness among people of African descent.

The focus on medical social theory declares the interest in the use of African American woman's body did not improve with science and technology (Savitt 1979, Byrd and Clayton 2001). Instead the interest of health and wellness for profit continued. Science continued to dehumanize black women.

Table 3.2 Slave Medicine -Treatments for Common Illness

Treatment	Illness
Tepid Bath of Leaves	Dropsy
Jimsonwood	Rheumatism
Chestnut-Leaf Tea	Asthma
Ho-Hound-Made Candy with Molasses	Cold
Cow Manure (Make Tea with Mint)	Consumption
Crushed Peachtree Leaves	Upset Stomachs

Source: Within the Plantation Household, Black and White Women of the South. Elizabeth Fox-Genovese (1988)

The epistemology of sickness, illness and disease historically consisted of two major cues:

- power and control will be used against them
- being sick means receiving race-based treatment.

The association between status, roles and positioning in society not only determines group membership but also influences construction of sickness.

Looking Beyond the Obvious

Dressler (1993) recognized that social scientists make a mistake when we oversimplify observations about ethnomedical beliefs and behaviors that result in inequality in health care. Blacks and women introduced into the medical system routinely had poor outcomes (Savitt 1978). The extensive research Savitt did over the years explains although poor whites were used for experimentation as well, blacks were considered weaker than whites. One of the reasons was blacks contracted disease such as tuberculosis quicker than whites. Difference in exposures to the disease was not considered. At the same time blacks were believed to be able to endure sickness and suffering better than whites (Bennett 1975). Therefore, they were used more often for experimentation. That is because, race and sex were both targets of power (Foucault 2000). Racist beliefs of those in powerful positions instilled negative feelings about blacks. This created certain myths about blacks that later became structural barriers for health care for black women.

White doctors treated black patients without being familiar with many diseases blacks contracted (Byrd and Clayton 2000, Dennis 1999). Blacks hid their sickness and disease to avoid receiving harsh treatments (Savitt 1978). This became a learned behavior. Paradoxically, it is unclear now which structural barrier is the major problem: if black women have poor or defective self-conceptualizations or if a culturally deficient social system failed black women.

Different outcomes for blacks and whites in the health care system are cited in most of the literature about health (Hahn 1995, Rosser 1994). What is the real problem?

Science and history attempted to progress in the same direction, to classify the black body as inferior. A pervasive approach has been used of caring for minorities traditionally excluding them from receiving optimal care (Dennis 1999). For that reason the aspects that influenced embodiment, experience, and identity of African American women must be considered when investigating their approach to disease. Then social connections can be made to bring women closer to a shared knowledge of the major health condition (Roseberry 1991).

A search for the epistemology black women have about breast cancer is incomplete without considering how white male-dominated structures denied them, the right to equal care. Then the starting point can be that, women have their own beliefs about the causes and the amount of suffering associated with diseases. Mathews (2000) work indicates women associate the growth with something dark and negative growing inside. Underwood (1993) study of 325 African American women in the Midwest shows African American has additional opinions about, medical research, and investigational methods for cancer. The study shows there are no significant and investigational methods for cancer. There is no significant difference between income and perceptions about cancer risk and personal cancer experience among blacks according to this study. What determines their willingness to participate in investigational protocols is whether or not the protocols are good or very good (Underwood 1993). Three quarters

(75%) of the participants indicated they are willing to participate in prevention or risk reduction, screening and treatment programs if they know they are going to, “get the best care” or “get along with the physician.”

Mwaria (2001) in discussing bioethics explains that what has been problematic is the cultural and social authority granted to physicians because it is a group that regulates itself. Furthermore, in the past they were only held accountable to themselves. It is no wonder that in Underwood's (1993) study less than half (43%) believed studies were ethical, while the largest percentage (46%) did not know if they were ethical. Investigational studies were believed to be either, “not good” or women “did not know”, (57%). I believe that the fact the second most common response for reasons to participate in trials (22%) was sacrificing oneself for science, should be of concern. Although, a larger percentage of women (28%) identified investigative methods as giving the patients hope, the fact that they identified the behavior as a sacrificial act, is an indicator of a culturally sensitive message. The message is they will experience biomedical racial profiling.

Being Profiled

This work supports the theory that as long as individuals have been different from one another (Derbyshire 2000). So prevalent is the problem of racial profiling in other systems in today's society that the United States General Accounting Office (2000) asked for a report on racial profiling. The American Civil Liberties Union investigated 12 police departments around the nation (Feagin 2000). Feagin calls racial profiling a harmful behavior used toward

individuals based on visual markers, mainly phenotypic characteristics, that is, skin color. Racial profiling is a term used to indicate the key factor for certain actions against individuals due to their race. Feagin further explains that the concept of unequal treatment for one specific group comes from a range of racist political, social, and economic practices designed to gain and maintain power. Cole (1999) speaks about those in power who target certain populations for certain types of encounters which prompts unequal treatment.

Still the concept of racial profiling has not infiltrated the anthropological literature. This literature shows few articles using the words "racial profiling." The largest source of information can be found under general academics where 243 articles are posted, with 14 added between September 11, 2001 and February 2002. Equally disturbing is the few articles found in psychology literature. Fewer than 10 articles address this problem.

Racial profiling cannot be completely dismissed because there are those who believe more attention is given to racial stratification than necessary. Derbyshire (2001) proclaimed racial profiling to be a "shibboleth" of the times. He feels racial profiling is another form of stereotyping, which is "an essential life tool" necessary in the use of science and mathematics. O'Sullivan (1999) agrees with Derbyshire (2001) and further comments that racist acts are labeled only when blacks are the victims. They both declare that blacks contribute to the social problem that encourages racial profiling.

During the last few years, the cultural construct of racial profiling has been limited mostly to the plethora of literature surrounding law enforcement. A

discourse on racial profiling--beyond the confines of traffic stops, physical abuse by law enforcement agents, murder and harassment during business trips--is rarely found outside of magazines and newspapers. It is only recently that racial profiling has become emblematic of discrimination.

Some of the literature shows black women are considered a muted group (Sherriff 2000, Matthews 2000) Support groups tend to focus on “educating” women, “teaching” women to participate in programs, or “teaching” women to find lumps on their breasts. Where is the scientific responsibility to explore the truths of slavery and how has it impacted black women’s ability to conceptualize adequate care?

The literature approaches the problem from the perspective that blacks believing themselves to be treated unjustly, they are less likely to seek care (Ashing-Girwa 1999, Bailey 2000, Blake 1984, Carlisle et al. 1997, Chen and Davis 1994, Danigelis 1996, Davis et al. 1996). A psychological approach, Freudian theory suggests blacks may avoid treatment because of repressed feelings about traumatic events. Freud’s psychoanalytical discussions explain that external events and experiences are stored in the memory and later acted out consciously or unconsciously. The Freudian libido theory suggests all behavior seeks to derive pleasure and avoid pain (Freud 1962, Devore and Schlesinger 1981). The anthropological approach to the issue of race and gender use a socially cognitive position, making several assumptions. These assumptions are that, a particular social representation among individuals exists; the shared general knowledge among the individuals comes from the same

source and basic general rules do exist (Van Dijk 1993). One important factor is left out, that is that the race of the individuals differs. There is little evidence in the studies of Chavez et al. (2000), Dressler (2000), Erwin (1996) Mathews (2000), that racial discrimination or racial profiling has been identified as a part of the social representation of the individuals.

Anthropological Approaches to Racial Studies

Dressler and Bindon's (2000) study with African Americans on high blood pressure medication measures the degree to which behavior and the individual's beliefs correspond. Dressler and Bindon look for cultural consonance. Chavez et al. (2000) question what Latinas believe are causes of cervical cancer. Mathews' (2000) work asks women to identify survivorship. The researchers regard economic, class, race, and gender as variables in their research, yet the variable race is regarded only from the most basic perspective. Baer, Singer and Susser (1997) suggest looking at where African American women are in relation to access to power and control. How does race position black women differently from others in relation to resources?

Race, Power and Cancer

One is asked to look at the race of the woman the level of power she possess and the severity of the disease. Until now most of the focus has been placed on the patient's responsibility to make changes. Little focus has not been placed on the medical system in explaining why late stage diagnosis is cited as the major contributing factor for the high mortality rate among black women. What becomes evident in a review of the literature is mistrust in the hegemonic

treatment modalities used as cures for sickness, illness and disease. Todd Savitt, Loudell Snow, and Ira Harrison's, are noted anthropologist who give clear accounts of unequal treatment for blacks. Mathews et al. (1993) work in rural North Carolina shows how women interconnect breast cancer with suffering. In their study "the preacher" woman would rather pray than return to a situation where she is ridiculed. She heard the providers ridiculing her beliefs.

Linda Hunt's (1998) study on cancer recognizes that cancer destroys the body in a treacherous, horrific manner. Cancer according to Hunt is perceived to be both deceptive and corrupt. Destruction of the body, deception and corruption becomes a part of the explanatory model (Kleinman 1980) of breast cancer among women holding these perceptions.

Singer (1997) offers another perspective on why after years of unequal treatment blacks would avoid the system. In his work on Juan Garcia he points directly to the system, stating the system is not designed to help every population. Byrd and Clayton (2000) verify this fact. Their work chronicled the disproportionate level of pain and suffering among blacks when they enter the medical system. Manderson (1999) clearly states desolation occurs for a woman with the embodiment of femininity when she is consumed by subjectivity. Subjectivity becomes a part of the empirical range of knowledge to the woman. When all of these factors are considered, it becomes clearer, why it is so difficult for black women to determine where the real threat lies.

The Real Threat

Missing from the literature on breast cancer is the direct correlation between breast cancers, lifestyle and health status that Sidel (1983) feels is necessary to understand the epidemiology of a particular disease. Lifestyle is influenced by how powerful the dominant culture is in a society. Attitudes, beliefs and behavior of a group are shaped by their access to power, wealth, and other resources (Roseberry 1991). African American women were denied access to all of these resources during the development of the new culture.

The threat of breast cancer as the leading killer among African American women prevails, as evidenced by their poor five-year survival rates. The American Cancer Society (2000) reports that African American women experience a 71 percent five-year survival rate when compared to the 86 percent five-year survival rate among white women. The barriers to breast health care are buried underneath the rubble of a deficient hegemonic medical system that has racism smoldering, keeping the unpleasantness of health care active. The unpleasantness comes from racial profiling which has a historical place in medicine that has not been addressed in the literature on breast cancer. The medical system has a poorly constructed bridge between those who produce medical care with those who cannot access care. The lifestyle of African American women was historically anchored in oppression, which insured culturally constructed racial markers would continue to have negative impacts on their ability to seek health care.

The Need For Silence

Thus, the habits, beliefs and behaviors black women have about breast cancer correspond to how cognizant they are about their status in society. Black woman have maintained a silent role (socially, economically and physically). Clear indications from Wyatt's (1997) study are that African American women are not taught about their bodies as women of other ethnic backgrounds are taught. Consequently black women must rely on extreme measures to take control of their lives. Silence is one of those methods.

Silence a culturally learned skill used in response to a culturally constructed deficient subsystem, slavery placed black women in a threatened position. Silence was empowerment during slavery since any form of resistance could be fatal. Little is known about the feelings slave women had or transferred to their children because silence was a tool and a weapon the women used. However, silence must not always be regarded as avoidance.

The noted social scientist, E. Franklin Frazier who wrote extensively about slavery in his work, examined the affective bonds black mother maintain in the absence of her child(ren) or family. From his work a monolithic principle maintains that the family and extended family motivate the black woman to keep on going in spite of her tragic experiences.

Accordingly, the psychological removal from nature, as black women knew it, coupled with removal from the family and further oppressive acts, eroded the emotional and motivational drive for black women to develop into the "ideal" American woman (hooks 1995, Davis 1981). Thus, the extent to which Black

women suffered from unequal treatment is immeasurable. Many chose silence as the way to suffer (Gaston-Hughes and Porter 2001).

Silence demonstrated by African American women is more than the refusal to speak about experiences. Silence is a pregnant statement (Sheriff 2001). It is also the inability to take preventive measures. Black women are afraid to touch their bodies according to Wyatt (1997). According to Brown, McGregor and Gary (1997), sex roles are operationalized, because of the way the black body has been treated, black women have become strangers to their bodies and their bodies are strangers to them. African American woman, according to the women in the study, want to reclaim control over the body.

Serious silence acts show up in the literature. During slavery, some black women quietly used extreme measures as protection, such as murdering their children or committing infanticide to reclaim control over their sexuality (Roberts 1997). During adolescence response to stories told about sex have been negative. According to Wyatt's (1997) research, stories told about sex are expected to frighten young black children, as a means of protection, leaves the wrong message. "...the messages about body touching and masturbation may be almost meant to limit curiosity about the body. However, the stories are so limiting that years later they are reluctant to check themselves for lumps or masses that may require medical attention.

Black feminist accept that black and white women were socialized into society differently. The arrangements for women in society were different, thus the health belief systems will differ. Understanding social arrangements is

important because when the political economy of the ethnic group is not carefully examined, the cause of the illness can be missed (Singer and Baer 1995). Once this is understood, it will help explain what type of care black women are entitled to and where responsibility lies which anthropologists (Bear, Singer, Susser 1997, Scheper-Hughes 1998) indicate is essential in understanding the conceptualization of the disease.

Conclusion

As far as improving the mortality rate of African American women is concerned, there must be an understanding that the institution of racism occupies a paramount position in the black communities that is not present in the white community. Therefore, material conditions have had a major impact on African American women's lives. The existence of racism in the community decreases the ability for black women to maintain power and control over their body, which is a requirement for good health. It is not the fact that blacks have unequal access to care that is most important; instead it is the poorer quality of care that is important. As long as patients have to be brought into the system by being eligible for care and by their doctor's recommendation the potential for profiling exists. As participants in this study explain, in order to survive breast cancer, black women must first go through this maze of obstacles, which they are unsure they can complete because they are profiled as inferior. Consequently, they sequester themselves to keep from being biomedical racially profiled.

CHAPTER 4 SCULPTING A PROFILE

Introduction

The process of collecting systematic, structured and reliable information in the African American population is challenging for scientists. Accurate opinions, correct measurements of knowledge basis and cost effective ways to get good samples are among a few of the problems identified. The goal for this work was to obtain a large enough sample of women who had some knowledge about the disease and felt they could candidly about the problems experienced by black women.

Getting to the right question to ask is often difficult. Given that the concepts race, and power are inextricably interrelated to any phenomena studied about blacks, these two variables are considered to have some causal effect. The correlation between race, power and breast cancer were the boundaries used to extract data for this study. It was determined that African American women do not go for screening and treatment for breast cancer. I believed perceptions were held about the breast cancer in the black community that differed from those in the dominant community. The data collected focused on political, economic, social or biological causes known in the black community. I asked individuals to identify which reason was the most significant.

Massaging the Materials

Barrett (1997) states an individual's belief system is actually autonomous, we must consider how it illuminates their social life, their ability to get through daily life. Given that attitudes, beliefs, behaviors and values shape culture and inadvertently set the rules for a society (Krober and Kluckohn, 1952) I felt the embodied concepts of self and the ability to receive health care were paramount in a discussion on breast cancer. Barrett (1997) also states that scientists must be careful pointed out that instead of seeking to understand the ideology or identity driven priorities of populations, too often they subconsciously impose their own attitudes and practices on various populations. I originally began this study testing role strains as the reason women delay screening and treatment. I believed women were overwhelmed by the multiple tasks they are responsible for on a daily basis. Barrett (1997) cautions scientists not to allow ideology-filled and identity driven priorities to disguise the problems. Taking his advice, I redirected the focus of attention for this study became to find the proper domain to study.

It was a pattern of negative outcomes that drew me to study breast cancer among African American women. I became more interested in breast cancer and African American women when I discovered that breast cancer was killing educated, uneducated, rich, poor, all types of black women who went in for late stage diagnosis. Some women have a fear of fatality from the disease so fervent that they refuse "to name it", in fear of "claiming it". They believe lumps come and go in the body." If you leave them alone, they will leave you alone "(Lannin et al. 1998).

'It became important to understand what type of structural impediments was so contaminating in the biomedical system, contributing to the death of black women for a disease that is nearly 97% treatable when detected early (American Cancer Society, 2000). I wanted to understand if this was a cultural issue. It appeared despite the high probability for positive outcome, the pathway needed to participate in screening and treatment sometimes seemed very narrow to the African American patient.

Setting the Goals

Several other anthropologists are taking critical examinations of the health care practices of the medical systems. Cheryl Mwaria takes a critical look at ethics issues surrounding minority populations. Hans Bear and Merrill Singer are noted for their critical approach to problems such as alcohol, HIV and other moral type issues with minority populations. Ira Harrison has written on slave health care, and public health issues. Diane Weimer works to help Native American women conceptualize breast cancer as a disease. Deborah Erwin developed The Witness Project[®],^a faith-based educational survivor support program about breast cancer for African American women about breast cancer. Erwin et al. (1996) study meets the beliefs" of the population rather than attempting to "change the beliefs". The construction and conceptualization of beliefs, values or actions of the women had to be carefully approached to understand why they will not participate in treatment for something they can survive.

Choosing to Work From Inside or Outside

Much of the current focus in social science on African American women and breast cancer is on structural barriers contributing to the disparity in morbidity

and mortality rates between black and white women for breast cancer (Crump 2000, Chang et al. 1996, Bailey et al 2000). Three major themes continue to be amplified in the literature:

- late stage diagnosis among black women (Cummings and Michalek 1983, Mathews et al. Erwin 2000).
- black women are identified as less likely to receive referrals for care from their providers (Erwin et al. 1996, O'Malley 1997).
- once diagnosed black women are believed to be two and a half times more likely to die from breast cancer than other women (American Cancer Society 2000).

Other structural barriers include access to care, economic issues, fear of fatalism, and lack of knowledge (Erwin et al. 1996). Attention tends to be placed on African American women making appropriate behavioral adjustments rather than on whether they are being treated fairly (Ashing-Girwa 1999, Chang 1992, Chen 1996, Cheverly 1996, Danigelis 1996). More studies are beginning to focus on genetic differences between blacks and other women. What has recently surfaced is the question about racial disparities and unequal treatment (Smedley, Stith and Nelson, 2002 Byrd and Clayton 2000). Byrd and Clayton work shows differences in medical treatment continue to prevail.

To understand the thought patterns of women, why disparity in mortality rates exist a combination of observations of analysis is appropriate. Pelto (1970) many years ago suggested using qualitative data to support theoretical information. This is consistent with Bernard (1995) who encourages using objectivity when gathering data in the field. These researchers suggest using the emic and etic approach to increase validity. The insider's (emic) view offers accuracy while the outsiders (etic) view increases objectivity. The decision that I

had to make according to Bernard (1995) is whether I was going to be a participant-observer or a observer-participant. Until recently, African Americans had little voice to communicate their beliefs about the difference in care and how it affects their ability to focus on breast cancer (Erwin et al. 1996, Mathews et al. 1993, Hughes-Gaston and Porter 2001). I wanted to ensure their voices were heard and valued.

Participants were recruited for this study through advertisements in the media including newspapers and newsletters. In addition, telephone calls to health providers, letters to medical students and letters to social organizations helped recruit participants. A purposive sampling (N=250) of churches, local business or community leaders and leaders as well as other social organizations were invited to participate in the study.

Working Through the Silence

A diverse group of black women were interviewed for this work. Professionals, paraprofessionals, rich, poor, working class, educated and limited skilled women participated. Different religious sects were represented including, Christian, Muslim, Yoruba and religious organizations not found in the dominant culture. In addition, physicians, nurse practitioners and medical students who treat black women were interviewed.

Providers, volunteers, and members from social organizations volunteered to participate in the study. Volunteers were from such organizations as the American Cancer Society's Brothers and Sister's Against Cancer (BASAC) and The Links. Women from the International Black Women's Study also volunteered to participate in the study.

Random sampling was used to recruit participants attending the International Black Women's Congress conferences. Purposive sampling was used for the African American Summit sponsored by the American Red Cross (ACS) because the women were specifically selected to attend as leaders in the community. Their purpose was to be educated with information to take back to the community. The women from the two conferences, American Cancer Society and International Black Women's Congress were targeted for surveys. Freelistings were conducted at the International Black Women's Conference. Overall, data was collected from three separate groups of women to determine the black woman's conceptualization of themselves and their embodied concepts.

Incentives

The first data set for the study was created from African American women attending the International Black Women's Congress 15th annual conference. Each quarter an IBWC meeting was held in one of four locations. The four locations were Cleveland Ohio, Newark New Jersey, Denver Colorado and Washington, D.C. Women are invited to attend the IBWC like any other conference that is advertised. A second data set was created from the African American Women's Summit sponsored by the American Cancer Society held in Orlando, Florida. A committee selected by the American Cancer Society volunteers identified these women. The final data set was created by five focus groups held in two different cities in Florida, Gainesville and Tallahassee.

Providers, breast cancer survivors and women never diagnosed with breast cancer participated in the focus groups. Focus groups and face-to-face

interviews were held in North Central and Northern Florida. Focus groups were held among both African American women and providers. The third group of individuals was health providers' doctors (residents, attendants & physician assistants).

Participants of the focus groups were recruited mainly through word-of-mouth. Advertisements in newspapers did not get a good response. The physicians' morning meeting at the University Hospital was attended to recruit physicians. Upon completion of the focus groups, each participant received a \$20.00 gift certificate as incentive. Most participants were not aware of the incentive until the information from the institutional review board was read. Evidently, the participants were highly motivated individuals.

Instruments

Survey's seemed too impersonal to capture what I needed to know especially for such an intimate subject. Also the women would have to self-report information and self-reporting is not always accurate (Bernard 1995). Interviews can be instrumental and versatile. Freelistings allow for a variety of feelings and behaviors to be captured (Bernard 1995). Pile Sorts and Triads were not used because the intentions were to triangulate themes of the data sets.

Four different methods were used to collect data:

- IBWC – freelistings (Appendix A)
- African American Summit – pre/post test (Appendix B)
- Focus Groups- (Appendix C)
- Face-to Face Interviews- Some Pilot Study Questions Appendix (D).

Information from each phase was used in the development of the next instrument.

With the assistance of consultants at the Harrell Professional Center at Shands, at the University of Florida a case using a standardized patient (patient trained using a script (Appendix C) was developed. This was used to generate discussion in the focus groups. Two models were used one using effective patient/physician communication another using an effective communication patterns was videotaped and reviewed by members of the focus group. The video is scripted to depict a doctor (volunteer) who delivers the “bad news” of a diagnosis of breast cancer to an African American woman who is a standardized patient. Participants in focus groups were asked to identify social and economic factors influencing beliefs that act as barriers to breast health care. Emphasis was placed on the situational, social and cultural meaning of breast cancer for African American women.

ACS women were provided pre-summit surveys during registration. In order to receive their incentive women had to complete the pre-test and post-survey. Women received their conference package after completing the pre-survey during registration. A book, “Celebrating Life”, along with a WNBA hat with a breast cancer ribbon embroidered on the hat, was the incentive for completing the post-survey. Participants in the focus groups received a \$20.00 gift certificate from The Lifting While We Climb Project, funded by The Susan G. Komen Foundation, Inc. Some women also received a free screening mammogram, from a different phase of the grant obtained from The Komen Foundation.

Conclusion

The difficulty for this study is that it is a combination of approaches including a reflexive study. Being raised in a large, urban Northern city I had to turn the culture of the South inside out and shake out some of my own feelings to understand the behavior of the participants. As an African American woman born and raised in Harlem, New York and having the opportunity to live in Northeast, Southeast, and the Southwest I had difficulty experiencing the same level of fear of the medical system as the participants. Eventually, I began to understand. For so long blacks in the South, died at the hands of others, usually those in power. It has become a part of their worldview that those in power, whether in the dominant culture or their own, have control and final determination of one's destiny.

CHAPTER 5 WOMAN IN THE MIRROR

Introduction

Blacks were often excluded from research until recently. Racial problems are poorly represented in the literature because of poor sampling or unreliable data. Challenges researchers face includes collecting data from a representative sample without it being expensive. An additional challenge was to see the situation from the eyes of “the other”, when I am one of the same ethnicity.

When I entered the field one the committee members questioned if I was really looking at, “the other”. The resolution came in difference in our life experience towards access to care. As an African American woman who grew up in Harlem, New York City, viewing a medical problem from the perspective of a rural southern African American woman, medical beliefs are from the view of, “the other”.

Being from within the same ethnic group, did not guarantee similarities. There were differences that had to be explained. I was challenged during the study by these similarities and differences. My urban upbringing conflicted with certain attitudes, beliefs and behaviors encountered by women in this study. In hindsight, I know this study was approved because the committee knew better than I that the personal and academic growth was going to be much greater than I anticipated.

Setting

Ashing-Girwa (1999) work addresses how difficult it is to recruit African Americans. In cancer control studies the churches are a popular setting. (Erwin et al. 1996, Ashing-Girwa 1996). Other research recommend culturally sensitive community based programs like The Witness Project® (Erwin et al. 1996) or Smith et al. (1996) act as the model. One problem I found in this study are the strong moral obligations conflict with their cultural beliefs so that women do not speak openly. What is right for the body? Therefore, I chose to survey large numbers of women at ethnic conferences.

Originally, a comparative study of women in New York and Florida (N=50) was to become the data set for the study. Influenced by Clifford Geertz (1983) suggestion that the phenomenon being studied is more important than the place, different sites were selected in order to capture the embodiment of femininity as it relates to breast cancer among African American women. Certain audiences within particular locations were targeted to see if choosing multiple sites would yield similar or different outcomes.

Individual African American women interviewed in the pilot study agreed role strains contribute since many had high levels of responsibility. However, they had concerns about more serious social issues than role strains, therefore, I abandoned role strains were the major barrier. A return to the literature showed there were endogenous and exogenous factors relating to the political economy of health such as poverty, lack of insurance, lack of education and reproductive factors contributing to delays in Blacks seeking health care (Crump et al. 2000,

Burnett et al. 1995, Powe 1995, Gary et al. 1996) as stated by the women in the pilot study.

Women participating in the pilot study (Jeffers, 1998) believed they did not receive equal or adequate treatment. Moreover, they believed if their overall social conditions improved they could receive adequate treatment. At the end of the interview consisting of twenty-four open-ended questions and a list, each one was asked:

Common experiences and research tell us that our race, sex, age and socioeconomic levels make a difference in our relationships with health care providers and the medical system. Have you, your mother, your sister, daughter or any female that you would consider family had a racist doctor or racist experience with medical care?"

Only one woman did not report having a racist experience and she did not appear to be African American. In fact, when she answered the door and invited me in for the interview I entered the living room and she excused herself for a moment. I assumed she went to get the person I was to interview. Mrs. Morris, returned ready for the interview. She did not have typical African American phenotypic characteristics. She was a petite woman with strawberry blonde hair appearing to be naturally straight, hanging past her shoulders. Her hair color accentuated her peach toned face that would allow her to blend in with the average European American population. If her features were used to profile her, there would still be confusion because she displayed a pointed nose with thin lips. Further neutralizing her racial status was an undetectable dialect void of any

specific geographic overtone. The interview with her proceeded as scheduled because when asked she self-identified as African American.

Using information from the pilot study to decide what to ask, over a 20-month period, from October 1998 until April 2001 data were collected from African American women (N=214) in three states, at four conferences, and in two cities in Florida using five focus groups. The pilot study, consisting of 50 women from two different geographic locations, Syracuse, New York and Alachua County, Florida was conducted. The intentions were to have women share their first experience and subsequent experiences with health care providers, specifically the permanent impressions left behind as a result of the encounter. Women between the ages of 35 and 85 with a mean age of 59 years participated in 1½-hour face-to-face interviews (Jeffers, 1998).

Women were recruited mostly by word-of mouth, women would tell me who to contact next. Women were asked to respond to structured and unstructured open-ended questions and complete freelists. Information was self-reported and behavior observed using participant observation. Information from the pilot study was used to determine that role strains were not the primary problem affecting African American women. The data for the role strains will not be reported for this study but information collected during the interviews relative to feeling profiled will be reported.

Locating the Population

The first challenge was to decide the population and how to select the population. I served as a volunteer in a community based culturally sensitive program as an observant-participant. The difference according to Bernard

(1995) is that I worked as a volunteer with this organization. Brothers and Sisters Against Cancer a support group established by ACS. Their purpose is to provide educational information, support outreach services to the minority population in the county. They spread the word about breast cancer and simple lifestyle changes that reduce the risk of cancer among African Americans

BASAC meetings were held one month over lunch. The setting was like a family because there were retired community members who knew one another since school years.

I compare BASAC to a family unit because the family in most cultures plays the three major functions in health utilization. They control the financial access to care. They socialize the individuals and establish the pattern of health care by demonstrating health-seeking behavior. Finally, they provide information and education about illness and providers (LeClere et al. 1994). Moreover they fulfilled one of the family's major roles in health care that is to influence when and how individuals receive care. They did this by providing outreach education and planning one annual major event a Gospel Gathering.

The gospel gathering scheduled every April resembled family reunion. Children and adults played games for prizes. Some games related to cancer health education easing the fear of discussing this sensitive topic. Prizes awarded included a grand prize of a trip to Walt Disney World. Gospel music provided by local church groups was the entertainment. This was a prelude to my formal entry into the field.

BASAC was a family with invited guests like myself. The minister and his wife who were ICONS in the community symbolized the moral leaders of the group. Members consisting of health care professionals, social workers, nurses, and survivors, those who were familiar with the devastation of cancer participated. There were three white women on the committee, a nurse, a health educator and an anthropologists who all headed subcommittees. Smith (1993) in his discussion on researching African Americans talks about the mistake researchers make by assuming that a report on Southern data is the opinion of the "white Southerner." I made a notation in my journal on the third meeting stating that I should learn how to speak at these meetings because; "suggestions from outside the family" were not welcomed. The three white women had a much better rapport as Southern white women than I did as a Northern black woman, as I noted in the journal. Furthermore the group made it clear that their major interest was not in "being studied". They invited me in as a volunteer, but they were not available for experimentation. Thus, I became an observer-participant (Bernard 1995) even chairing a few committees.

Unfortunately, the stability of the group was continuously threatened by a high turn over rate of personnel within the parent organization. The group was advisors (four during my two and half years), would leave discouraging the group. One employee did not hide that she did not want to work with the group unless they agreed to conform, meaning be exactly like the other support groups. A review of the mission would have revealed the group was established at the

request of the parent organization to provide outreach services because they could not reach blacks in the community.

Each time the group reconvened after a lapse in time while waiting for new hires the numbers decreased. Furthermore, the new hires were rarely informed about the purpose of the group instead they were familiar with the individual behaviors within the group. Added to this frustration from both the employer and volunteers was confusion about why BASAC did not raise the same amount of funds for the parent organization as other groups.

Despite BASAC leaders attempts to explain how limited the resources are in the black community, the parent organization continued to insist on fund raising. Volunteers in black communities already struggle with limited resources, having to support school events, athletic events, and church events inside the community. When they must participate in activities where their monies will also leave the community that puts an additional strain on the community. This was a continuous communication problem that was unresolved when I left the field.

Eventually, discouraged members drop out and fewer meetings were held. The groups continued. In my last year I participated in less than six meetings. The major event the gospel gathering that at one time had 500 community members attending, was not held the year I left the field. I became a member of the planning committee for the American Cancer Society's African American Summit as a result of working with BASAC. This was the way I showed reciprocity.

Another way I showed reciprocity was as a certified triple-touch instructor. I trained women on breast self-examinations during educational programs. I also supported the co-chairs of the group by obtaining information on grants. I helped co-chair and coordinate the annual fashion show at the gospel gathering with a long time local resident. As chairperson for the fund raising committee for the gospel gathering the committee raised over \$5,000.

In critical medical anthropology the environment as it relates to health is a way of accessing human susceptibility to disease. Gorey and Vera (1995) show in their research on black women and breast cancer geographical location has certain health implications. How does that relate to culture and location?

Among African Americans there are particular social and political conditions within the environment that have bearings on cultural beliefs that are not calculated into the research findings (Hahn et al 1995). I was frustrated because I did feel a comparative study between white and black women would answer the questions that needed to be answered. Dr. Doty, suggested I attend the International Black Women's Conference and interview women at the conference. Not having a budget or any money, I had to find an inexpensive way to attend the conference.

When and Where I Entered

I consider this my true entry into the field. Technically, this is the next phase of my entry into the field, the International Black Women Congress, 15th annual conference. After having a few discussions with Dr. LaFrancis Rodgers-Rose, sociologist and explaining what I was trying to research she offered to sponsor me as a "young researcher". This became a term of endearment, she still use

when referring to me. I have a great appreciation for her sensitivity. She provides me with much needed advise, linking me with women who are experts in their fields, who are now wonderful friends and mentors. Even during her very sudden and serious illness, while she waited for a heart transplant, she continued to check on my progress.

During my planning process for the first conference Bernard's (1995) suggestion to understand the layout of the site and the social planning did not fair strong enough in my preparation. I assumed that as an African American woman I could enter the setting with more ease than women of other ethnic backgrounds. I approached the first meeting with the usual amount of confidence one has in going to a conference. I was conservatively packed with traditional conference attire. Garbed in a comfortable neutral colored conference slack suit, my hair was neatly manicured. I had a touch of make-up impeccably placed on my cheeks and lips to highlight my face. I traveled to the first location Cleveland, Ohio. I was well rehearsed in the hypothesis for the research in case I was asked to explain in detail. After all I an impressionable young anthropologist confidently trained by one of the best, H. Russ Bernard. I practiced how I would answer questions about my research using my very anthropological academic language.

Learning to Speak the Language

Language at the IBWC is important. The organization's focus is on taking parts (women feeling fragmented) and making them whole again. The language in the IBWC mission statement is carefully constructed. They categorize themselves as a "global community of women of African descent bound by our ancestral spirituality]." The mission of the organization is to envision and

understand the different cultural belief systems held by African American women throughout the nation, so black women can be empowered socially, politically and economically [sic]. In addition, the intentions are to be able to define themselves, embrace themselves and improve themselves in order to produce exemplary models of African womanhood for the next generation. IBWC use reflexive social theory as a framework for their organization.

Business of the Meetings

Meetings are held at large metropolitan hotels in urban cities, walking distance from fine restaurants and tourist attractions. Usually two to three hundred women attend the meetings. IBWC conferences have the traditional format of a three-day anthropological or sociological conference consisting of plenary, workshops and breakout sessions. The major difference is in the greetings. IBWC women greet one another in their traditional manner embracing one another, rather than the polite professional handshake.

The conference is like any other conference, in that an atmosphere is created. The controlled setting of an ethnic environment allows women to practice their traditional behavior patterns by being physical when meeting one another embracing and sharing traditional greetings, rather than the greeting used in the dominant culture of a handshake.

It is apparent at this during the greeting how society, redefined who we as black women are, how and what we feel for one another. Four years ago, I entered this stating, "traditional behavior" is considered something that should be kept "behind the scenes." I added that close physical contact with one another is something that we were not showing in the open. Women exchanging feelings of

love, appreciation or respect for one another should be kept behind the scenes. Even I am surprised that I chose to describe this as “backstage behavior” in my ⁷journal as a way of defending a natural practice. Although I am an African American woman, I think that statement alone from my journal dated December 1998, shows I conceptualize my identity as the “other,” the participant observe, more than I realized.

It was evident at the first meeting who I had become because I was not prepared for the greeting process from my “Sistahs”. The amount of love I received in an open environment was wonderful. I’ve never turned down the opportunity to go to another IBWC meeting. It is rejuvenating.

I Hope This Is My Mirror

To understand the IBWC it is important to become engaged in the experience from the time of arrival at the airport of the location of the conference. The experience begins on the shuttle from the airport to the hotel. Usually, there is someone else on the shuttle, since women tend to arrive in groups.

The woman boarding the shuttle behind me was an African American woman. She sat directly across from me and was amazing. The woman looking back at me appeared to be about my age (40s) but at the same time she was eternal. It was evident she was a professional. She beautifully displayed her gender and race in her elegant but comfortable attire. Her hair was adorned in small individual two-strand twist articulately placed into what looked like a tiara. The tiara surrounded the crown of her head accentuating the beauty of a mocha

⁷ Journal entry dated December 4, 1998.

colored silk like face free of make-up, markings or blemishes. Ornamented with just a little ethnic jewelry one was free to admire the long flowing black dress highlighted with small brown and ethnic symbols throughout the print. As she moved to the middle of the shuttle her dress flowed with the swiftness of a summer breeze. I was hoping I was looking into a mirror. I knew this was the image I wanted to portray someday, beautiful, confident, professional a proud example of both my race and gender. The reality of the other becomes fixed.

The open-ended interviews began here without my knowledge. We looked at one another exchanging smiles. During the 20-minute ride to the hotel we fell into conversation. She was also excited about attending the meeting for the first time. Thus, the fieldwork begins.

We arrived at the hotel in Cleveland around six in the evening. About eight black women were sitting in the café area dining, some having coffee and others engaged in light conversation. As we entered the foyer I did not think anyone noticed us but by the time we reached the check-in desk, we were wrapped in warm hugs and greetings from the Sistahs, none of whom I knew personally. It was then that I discovered I was traveling with one of the speakers, a professor from Washington, D.C.

Before we could move away from the desk, another woman arrived right behind us and was brought into our circle. She too was a professor. She was on the Board of Directors for the organization. Yet, the greeting she received was no different from the greetings extended to every other woman who arrived over the

next hour as we sat and chatted in the dining area. Immediately what emanates from the group is a strong sense of humility.

Meeting the IBWC Women

The founder and president of the IBWC Dr. La Francis Rodgers-Rose, a sociologist, immediately checked us over as any mother would do to ensure her progeny traveled without harm. She appeared to be in her late 50's. I later discover I am a decade or so off in estimating her age. Her bright smile and warm hugs is nourishing to the hungry souls of these black women who suffer from the positive emotional droughts while performing in academia, the corporate world, the health care sector or the community. She introduced us to one another. Then she shares something about each one of us so that we are no longer strangers to one another. She connects us from the beginning so we will never feel isolated.

Recently in a discussion with her sister, Cynthia I learned that the ability to connect women is innate behavior for Dr. Rose. Cynthia explained that growing up there were four of them. Using metaphors to explain their social conditioning and how connections were made to one another she explained.

As children our mother told us she had a dollar to offer them in life (this dollar was the sum of her knowledge, skills, talents, finances). We would each receive a quarter to make it through life. We might each have to use the quarter differently. One may even lose their quarter. Whatever happens we need to remember to be prepared to share a part of our quarter with the other three siblings. So we learned in life we must share, help, and stay connected.

Dr. Rose takes me by the hand to be sure I am connected to the Regional Director who is in charge of Florida. Corrine is one of the oldest members of IBWC who is approaching the age of 70. After exposing me to her beautiful smile she gives me another warm hug. Then she informs me I am her responsibility for life. Elders in the IBWC take their responsibility as very seriously much like their ancestors (see Chapter 3).

Elders have arms that appear to grow longer as more women come. The women wait to be embraced as the elders take their turn embracing the women. Interestingly, Dr. Rose nor Corrine fit any stereotype. They are neither matronly, nor elderly. They are ethnic; Dr Rose wearing carefully manicured waste length dread locks and Corrine displaying beautiful African attire.

Dr. Rose stops for a moment to ask the two women who arrived at the same time as I how they were doing. Both women expressed feelings of emptiness after recently experiencing the loss of their mother. Dr. Rose expressed her appreciation to the women for coming to the conference in spite of their losses. She then assured them, “not to worry we will take care of you”. This increased my oneness with this group because I too had just lost my mother.

Like the atmosphere at BASAC's gospel gathering, this is a family instead setting rather than the traditional conference. About twelve black women in the lobby, listened to one another as they provided updates on their lives, their health, their families and offered feelings about current events.

Acknowledged Family Membership

Four months later, in Newark, New Jersey, the second meeting of the 15th annual conference occurred. The arrival experience was the same except now I

knew some of the faces and names. The traditional greetings took place the same as in Cleveland. Women catch up on who was well and who was not well. One of the organizers has sickle cell anemia and was not feeling well. Women made offerings of natural remedies to comfort her such as, teas, massages, and acupuncture. Every so often someone is heard asking about her condition.

As a black woman who spent her developmental years through high school in Harlem, New York City, I perfected hanging out which Bernard (1995) suggest is important in participant observation. Hanging out is simply being present in a space, listening, observing and engaging in conversation with people as they come and go in a particular area. In fact, that is how I made the correction from not understanding the lay out in the beginning. In Newark, N.J., twenty of us sat on the floor in one of the hotel rooms the first night and shared carry out meals. Without knowing it I became the key informant in Denver, Colorado.

I arrived in Denver, Colorado, the day after the second bombing at Florida A&M University, where I am employed. The bombing of one of the largest Historically Black Colleges and Institution brought back memories of church bombings in the south during the civil rights movement for blacks throughout the nation. This was very disturbing to the black community.

The program indicated someone from Florida A & M University was presenting. Dr. Rose assured everyone news would soon come to the group. My safe arrival was more significant than I realized. I arrived in Denver quite shaken from the activities of the preceding day. I was on the program and did not have any of my materials because my office was in the building bombed the previous

day. The FBI immediately secured the building after we evacuated and it remained that way for several days. I also arrived without knowing how much damage was done to the building although I knew no one was hurt. I was greeted with such a sighs of relief. Seeing one person that safe, symbolized safety for all of us. I was the new key informant. I felt safe now that I was with my Sistahs.

We discussed the horrors of the event family style, in a circle with them offering pats of comfort to the back and many opinions about the cause. Once there was assurance no one was injured we proceeded to do the next natural thing. We prayed about it together. Then we took a trip into the mountains, shared lunch, prayed again and prepared for the conference. Throughout the day women approached me to hear the “real story.”

A major difference between the IBWC conference and other conferences is the methodology used to educate black women attending the IBWC. A combination of Western knowledge based material (health education) and spirituality is used to inspire women to take better care of their bodies, mind and soul. The day is opened with a special time set aside for prayer and meditations for those who would like to participate.

In the first session libations are poured by one of the female spiritual leaders⁸ to honor the ancestors. The focus is on empowering women of African descent and providing spiritual protection. IBWC women are encouraged to

⁸ Libations are poured to honor those who have come before us, ancestors. Water, which is blessed, is poured into a container and the person conducting the prayer disposes of the water, usually by drinking the water.

regain and retain both the knowledge and the ability to heal “thymself” [implications are this was taken away when enslaved].

Planners of the conference meticulously recruit accomplished speakers. Scholars from institutions such as Harvard and other highly acclaimed institutions present. Experiential presenters also participate. Dr. Rose compiled some of the voices of the presenters of IBWC in a book entitled, *River of Tears: The Politics of Women’s Health*.

The theme of IBWC supports Dr. Delores Aldridge’s (1993) work. Dr. Aldridge’s explains that health of African American health should not be divided into reproductive and non-reproductive functions. She explains that the triple threat of racism, sexism and ageism complicates any health condition blacks experience. Her findings are that included in analysis of the health status of women of African descent one must first deconstruct how women of African descent were traditionally assaulted both physically and mentally. Once this is complete possibilities and options to care for black women can be explored. Messages such as this are spirited changing even the energy in the hotels.

The conference structure has more similarities to academic conferences than differences. The President opens the first plenary session by delivering a charge. Then a direct correlation between positive outcomes for major sickness, illness and diseases and spirituality is made. This is the difference in the conference. According to Dr. Rose, spirituality produces positive mental health (verbal statement in opening of conference).

Regular breakout sessions feature a topical focusing on multiple issues. Presentations are based on funded research projects, using quantitative, and qualitative data, community projects, with a high focus on applied work. Two traditional luncheons, one each day, are held where individuals are honored for their contributions. The first luncheon is an award luncheon for the Oni Award recipients.

In addition to the sessions, and luncheons exhibitors have tables to display their materials. Materials include African artifacts, books, clothing, art, health care products and other items. Many of the exhibitors are people who have knowledge about alternative medical approaches. Some focus on traditional healing. The importance of promoting good health is evident by the licensed massage therapists who remains on duty at all times to provide massages to women who experience discomfort from being inactive during the conference. Also a licensed acupuncturist is available. The IBWC 15th annual conference and the African American Women's Summit were selected as two conference sites to collect data because they used creative processes to construct behavior uniformities within their environment.

African American Women's Summit

Under the guidance of the, Director of Medical Affairs at Division level and the leadership of a volunteer who chaired the committee, individuals were recruited to organize and African American Summit for the American Cancer Society. The committee consisted of all African American females and one male with the exception of Nina and her staff. The male did not remain on the

committee because he was a cancer control director who changed jobs before the summit.

The planning committee consisted of thirteen ACS volunteers recruited from North, Central and South Florida. Professions represented were a Physician (MD), Nurses (RN), Social Workers (MSW), Breast Cancer Survivors, ACS employees, and volunteers and leaders in the community. From April to October monthly meetings were made. All meetings were held by conference calls. In the beginning there was lots of brainstorming to determine what information should be provided. Since meetings were held by conference call many of us did not know one another by face. I did not know anyone on the committee. The ACS in Alachua County provided my name to the committee. Meetings were always structured therefore the committee moved through the process of organizing the summit quickly focusing on educating black leaders throughout Florida.

The 2015 goal of the American Cancer Society was to achieve a 50% reduction in age adjusted cancer mortality rate therefore the African American Women's Summit was planned as one of the first steps to meet the goal. The major reason to focus on African American women: is it is anticipated that by the year 2015 there will be more blacks in the state of Florida than in any other state (ACS, 2000). Also nationally, Blacks have a higher mortality rate for breast cancer than other populations as previously reported.

Reasons women came to the summit were different from the reasons black women attended IBWC conferences. Women at the IBWC want to learn to improve their own health in order to be the model for others, thereby influencing

behavior by example. Hughes-Gaston and Porter (2001) declare that black women are very comfortable caring for others. Women attended the Summit to learn how to take the information back to “their women.”

Cultural Features of Summit

ACS receives a grade of A for effort. The African American Summit attempted to move away from the traditional conference forum. However, the presence of the white employees of the Cancer Society who attended the meetings compromised the meeting. In retrospect were the intentions to help the white employees learn to work better with minority populations; An alternative was to pass on information: A third point was to showcase the programs. All of these things occurred. According to the mission of the summit the program was designed to encourage women to adopt intervention methods approved by the American Cancer Society.

Meeting the Women at the Summit

Hughes-Gaston and Porter (2001) declare that black women are very comfortable caring for others. Women in Gaston-Hughes and Porter’s work point out that African American women provide care from a position of both submission and commission. Historical accounts of assigned roles given to black women (Fox-Genovese 1988, hooks 1990) indicate the role of caretaker is as learned behavior from slavery. Black women learned to commit to the person they provide care for to become responsible for the person to the point of sacrificing their own life (hooks 1996, 1981).

Women who attended the summit were selected to attend by the committee formed from volunteers throughout the state of Florida who worked with black

women and breast cancer. Cluster sampling was used to recruit representatives from organizations, churches, schools and PTAs, state legislature, cosmetology salons, public health professionals, social workers, Florida State Breast and Cervical Cancer Coalition, African American Sororities (all five) and ACS. In addition, each committee member could recommend individual. A special invitation went out to women who were respected in the community members thereby becoming key informants for the project.

Women attended the Summit from the position of power and commission. The intentions were to learn how to take the information back to "their women". Consequently, the climate of the summit differed from that of the IBWC despite bringing women of the same population together for the same purpose, the disparity in black women's breast cancer treatment.

The chairperson of the committee emphasized the need to dispel cultural myths specifically citing the popular ones, "I have a lump but if I ignore it, it will go away " and "If air hits it, it may spread." ACS also took the position that they wanted to dispel as many myths as possible. Three themes evolved to provide scientific knowledge in lay terms so the women could better communicate about the disease:

- To explain the etiology of breast cancer
- To demonstrate effectiveness of culturally sensitive programs
- To increase the number of African American female volunteers.

"When Spider Webs Unite They Can Tie Up a Lion", became the title for the African American Summit" to symbolize the desired outcome of the conference. This African proverb challenged the population to come together "to fight breast

cancer", a phrase used throughout the summit. The summit was one day and women were invited with ACS picking up the tab. Women arrived the day before. A luncheon was held for the committee on the first day but a few from the committee attended. Most of those attending knew one another.

In order to receive a packet for the summit women had to complete a pre-survey. The summit opened with a welcome from the Chairperson of the summit with introductions of the members. For the next seven hours, survivors, health care providers and volunteers provided scientific and experiential data.

The committee orchestrated a group of presenters that could motivate the audience moving from myth through the biological facts of breast cancer. A plenary session on the epidemiology and risk factors associated with breast cancer opened the summit with Dr. Saundra Million Underwood as speaker. Applied methods provided by individuals on panels with community-based practices preceded the educational luncheon (Purple Tea).

Representatives from the State Department of Health as well as State Legislatures provided advocacy. The luncheon was a purple tea.⁹ Towards the end invitees were seated according to districts within the state. In roundtable discussions each table was asked to discuss the intervention methods they wanted to adopt. At the end of the discussion period, each group made a commitment to accept an intervention program for their area. The summit ended

⁹ A purple tea is an educational luncheon designed by American Cancer Society for use by African American volunteers to teach women about breast cancer. There are certain requirements to hold a purple tea. The educational program must be held by an individual certified to provide training and The Warning, (see attachment) a poem must be read. The room is decorated using purple and women are asked to wear something purple. It is modeled after the teas where women socialized and exchanged information before so many women entered the job market.

in time for people to travel home and make it home by early evening. At the end of the conference a four-hour training was offered to certify triple-touch instructors, a method used to teach women breast self-examination (BSE).

Unlike the IBWC, where women are connected by race, religion and spirituality women at the African American Summit link was through their volunteerism or leadership positions. Women from the African American Summit are what Oliver Sacks (1988) refers to as, "Centerwomen". Centerwomen are the public spokespersons for the cause. The IBWC would not be considered centerwomen because they are a group whose core consists of traditional beliefs and ideas, furthermore their values are products of what happened to their ancestors (Krober and Kluckohn (1952). Women at the IBWC do not feel compelled to move in between two cultural worlds instead they tend to approach their daily lives in the same manner as their ancestors, carrying many of the traditions.

The two groups shared a common purpose in coming together. Both groups focus on networking. The difference is the IBWC women place more emphasis on the strengths of the group. They form a family. They build upon one another.

Hildredth (1999) gives six characteristics and strengths of a family, they share five of the six:

1. strong kinship bonds
2. strong work orientation
3. strong achievement orientation
4. flexible family roles
5. strong religious orientation

I stress the importance of family because much of the knowledge shared comes from ancestral information passed on through the generations. You hear a lot of, "my mother told me...or my grandmother told me". Black family beliefs and values that are transmitted through the ancestry act are the adhesives for the group (Hildredth 1999).

The different settings were well constructed forcing the use of interpretive analysis. Race played a different role in each setting. The focus groups brought in some clarity. Four categories of participants were selected for the focus groups: 1) profession; 2) membership in social organizations; 3) or as a breast cancer survivor or 3) never having a diagnosis of breast cancer.

The setting for the focus groups was a Southern city with an affluent health community. There are three major health care facilities with an estimated 1,280 beds total at the setting. Connected to the University are a medical teaching facility and a leading referral facility in the Southeastern United States with a cancer center. They performed an estimated 36,000 mammograms in 1997. These are based on referrals from all over the Southeast to include 400 from the local Veteran's Administration.

Gainesville is seated just 102 miles from the center of the state where the summit was held. The population in 1999 was 216,249. The most recent census (2000) listed Gainesville as one of the Metropolitan Statistical Areas with a low unemployment rate (2.1%). Nearly half of the county (48.7%) is in the labor force. The government employs the highest percentage of workers 35.0% (state) in the area according to the Florida Health and Human Services Commission.

All focus groups were held in familiar settings for the participants. Women who were physical plant workers (N=8) from the University assembled in one of the nicer conference rooms in a University building. Over lunch or light snacks, participants were asked to discuss how they are treated in the health care setting. The first discussion took place in a large conference room. It was the room the workers traditionally clean. They selected the location. All women attending were dressed in working attire. The supervisor who normally attends focus groups did not attend this meeting. Women attending the meeting were on equal levels of employment because the supervisor did not attend the focus group.

This was not the first time they participated in a focus group but this was the first time they participated alone without their male co-workers. Participants assumed the same position of any other person who frequented that room to voice their opinion or critique sensitive materials. The focus group lasted for one and a half hours with the women leaving to go home at the end.

Medical students (N=11) participated in a focus group in a classroom in the medical building. Lunch was provided for the group beginning at noon in the middle of the week. Only two students wore their white coats. Another student draped the white coat over their arms. Others were dressed in regular working attire. Fifty percent of the group was African American with one African American male attending. The lay out of the room was different from the University employees because the students sat in a U-shape, which allowed for better conversation.

Two focus groups were held in the early evening at the downtown Public Library because of the central location of the library and easy access to parking. One group consisted of African American women belonging to an upscale ethnic national social organization. In order to belong to the organization, women must have a certain income and educational level willing to perform community service. Most women who participated in this group came after work and were dressed in professional attire.

The second group to meet in the public library was a small survivors group and consisted of four people therefore information from this group will not be used. Both groups were provided light evening snacks during the discussion of breast health care Among African American women. The final focus group was the largest group, survivors groups (N=12), held in Tallahassee, Florida. It took one attempt to the coordinate the group in Tallahassee. It took several telephone calls and letters to get persons to attend in Gainesville.

A community home established as a place to give educational programs, Great Recoveries is where this focus group was held in Tallahassee. Over light evening snacks women introduced themselves to one another. Women came from work therefore they were dressed in attire that corresponded with their job to include one woman who wore scrubs.

Conclusion

At first glance it appears that ACS may have taken a multicultural approach to the conference process. Multicultural refers to an organization in which all of the members cultural ideas are accrued, appreciated, and utilized as a part of the decision making process in order to improve the overall effectiveness of their

mission (Better–Reed and Moore 1995). That means looking to see if through text and talk the issue of race and breast cancer was effectively addressed.

In using the multicultural approach, discourse analysis must be considered, Van Dijk (1993) conducted studies on racial prejudice finding that discourse analysis is relevant when addressing racism because whites can inadvertently replicate their positions of power through text, talk and behavior. Although, a multicultural committee used a multicultural approach to organize the Summit, the positions of power were enforced in the end. At the end of the summit the organizations was asked to committee to using an intervention program. The model designed by ACS did something similar. This may have been perceived as a power move.

Using Van Dijk's (1993) argument, ACS continues to show social dominance by designing and formulating programs to connect to ACS. Where were the options? Outside agencies, such as representatives from The Susan G. Komen Foundation, Inc a funding agency or AVON were not invited to help women. Secondly, ACS only recently began to display their partnership with black survivors. Gibbs (1997) in his discussion on Afrocentrism declares that African Americans are rooted in African social models. They must be available and believable. Van Dijk (1993) explains in his work that a picture of the mental and social model should be available to individual and the group. Dr. Underwood is a person whose work I strongly admire, but the first survivor at the ACS meeting the women saw was a physician.

On the other hand, at the IBWC meetings it is not uncommon to see an award recipient be a woman who is not degreed. At the last IBWC meeting I attended one of the highest awards was given to a woman who was as a teenage mother of three, was once incarcerated who is now the director of an outreach program that has ten case managers under her. Her program provides outreach to women who are in abusive relationships or have addictive behaviors. She was receiving the same award as the Director of a major department of a private university in the state of New Jersey. The message is that the women and their work are of equal value.

In both locations there is a strong feeling of the need to belong. IBWC is handles this well because the structure models the family. It is all rooted in African tradition. They provide music and, religion, talks on male and female relations. At the summit the need to belong is noted in the apparel of the women. Women at the summit wore clothing symbolizing their organization. For example women in sororities wore their sorority colors. Ms. Black Florida wore her Sash and crown. A few women had on ethnic attire, such as Mrs. Hudson, Chairperson of Sister's Alive a support group in Tallahassee. However, I later learned this is daily attire for Mrs. Hudson. She like the other women identified with what they wore on a daily basis rather than their ethnicity. For the summit, women identified more with their social group than their ethnic group.

Overall, the setting was different from the IBWC because the women attending the summit were identified based on influence in the community. The summit was not being sponsored by an ethnic organization still the intentions

were to promote culturally sensitive discussion about black women with ACS staff representing the dominant culture.

In the beginning I failed to appreciate the importance of events such as the gospel gathering, or the loyalty to groups and organizations that occur in the Southern region. After I left the field, I had a chance to reflect on things I would have changed. I didn't think when I began my research that I would "go native" and become, "infatuated" with attending activities such as the local level high school football games. I soon found myself at the Thursday and Friday night games and working as a volunteer in the community organizations group.

Coming from a diverse social science background including psychology, social work and now anthropology accepting the values, beliefs and attitudes of the population was supposed to be an easy task. I should have felt comfortable. Several things occurred that retarded my field experience. First, I did not have good documentation introducing myself to the women involved in groups as Bernard (1995) suggest. A parent brought this to my attention in a personal conversation, by saying, no one knew, "who my people were." This means I could not gain trust of the local individuals until they could verify who I was and what I wanted. Secondly, when I identified myself as an anthropology student studying why black women present so late for screening and treatment for breast cancer understandably the level of trust dropped further. This population is tired of being used for experiments (see Chapter 3).

A potential obstacle was a long-standing history of poor access to one of the local hospitals. This study was conducted out of one of the largest health

care facilities in the Southeastern region. None of the local African Americans interviewed were born in that facility because of segregation. They were more familiar with one of the other hospitals in the area considered the "black hospital" until the late 1960s early 1970s according to local informants. Only a few women had their children or were ever admitted to the larger facility. One of the leading Cancer Centers is located in the larger facility. There were concerns about trust and invasion of their privacy. Further influencing their mistrust was my northern accent and attitude that interfered which at times interfered with their beliefs as well as my own. I thought that because I was black and because this was a culture where information is passed on verbally I could enter the field with fewer formalities. It is very important to carry documentation and not rely on visual markers.

I could have connected earlier if I relayed that I was on faculty development leave from a Historically Black College and University (HBCU). I should have downplayed the connection with the predominantly white institution and established my position in the community based on my position at the HBCU. They trust faculty members from the HBCU. My northern upbringing kept me from being aware of the significance of this important tie. I would have obtained information at a more rapid rate if I connected with my faculty position. Because of the decision to align with the white school when I mentioned the word study in meetings, I was quickly reminded, "don't you think we have been studied enough" or, "let's not have a repeat of Tuskegee." Undoubtedly the impact exploitation had on rural southern African American women took me a while to

understand. Now I understand that we look alike but the issues of power, authority and domination stand between us. There are different reactions and responses because it was enforced in different ways, in different geographic locations. This influenced the culture of sickness, disease and illness.

Living through segregation these women had to look power in the face on a regular basis. They had to stand toe to toe with power. They had to make power move over. They are all survivors of a disease that has been out of control. Not having this experience.

CHAPTER 6 UNDERSTANDING HOW RACE MATTERS

Introduction

The pilot study was conducted to determine if role strains was a major barrier to care. Information from the pilot study is reported here to show comparability. After reading the informed consent and obtaining signatures, pilot interview began with demographics followed by asking respondents to recall their experience with a medical provider, to tell, who it was, what they did and the impression it left with them. The age of the women (>40 years) did influence the stories. Segregation was still heavily enforced from the 1950-1960s in the south. Only three of the women were born or had early childhood in the North, therefore all of the stories were about a provider, midwife, or nurse coming to the house to provide treatment in the South. With the exception of one respondent all of the women gave an account of what they perceived to be a racist experience. Mrs. Morris, the woman who did not have a racist experience may not have had the same experiences because of her physical appearance (see Chapter 4).

The pilot study was conducted using free listing, surveys and focus groups in which women responded to what influenced their health seeking behaviors. Structured face-to-face interviews conducted in a pilot study (N=50) determined that nearly all of the women experienced a racist interaction or knew someone close to them who had a racist's experience.

Table 6.1. Results from the New York and Florida Study

Percentage of Women Responding	Percentage of Women Having Racial Experience
N=50	98%

The women were asked to respond to twenty questions. The interview ended by asking women to respond to the following question:

"Common experiences and research tell us that our race, sex, age and socioeconomic levels make a difference in our relationships with health care providers and the medical system. Have you, your mother, your sister, daughter or any other female you would consider family had a racist doctor or racist experience with medical care?"

The researcher did not define the term "racists' experience" for the women. The women were asked to explain their responses. Each woman reporting, gave an experience in which she or an acquaintance was denied equal or adequate treatment.

The most compelling story in my work on ethnic amplifiers is from the pilot study. Momma GeeGee, a 75-year-old retired housekeeper, raised in Pomona Georgia tells this story in response to the initial question to recall her first experience with a provider.

After the all-white patients were taken care of that evening, that's when they took the black folks in. I was taken in and he didn't get me any kind of medication (there was no more pain medication left). He was just so indignant. Oh, it was really frightening but I had no choice. I never will forget it. I think about it now sometimes. He propped his feet up on the sofa and then he started to pull my teeth out. My whole body went up. It just hurt terribly and then he swore at me. I thought you'd be like this, he said. I had no choice. If we had not been taught that we were God's children just like we really are, I would have felt like an animal or something. Momma GeeGee's daughter, Mrs. Howard is between the ages of 45 and 54.

She shared the same story nearly verbatim in her interview held one hour later and approximately 5 miles away. Mrs. Howard was not aware of her mother's participation in the study. Here is evidence that information about health care is passed down on through the generations.

Mrs. Howard was made aware of two points: the unequal treatment received by her mother because of her race and that she had to learn to rely on another factor (God's love) to bring her through these types of experiences. Women in each of the focus groups spoke of having to rely on God's love as their source of strength.

Several women reported as Momma Gee and Mrs. Howard both stated early in the interview, they trust their doctors, do not have negative feelings about treatment, and do not think doctors discriminate. Yet, both recanted the story without hesitation or delay as though it happened only a few hours before the interview. The seed is planted deep into the psyche.

Findings, showed the relationship between role strains and screening and treatment were spurious. Racism was a more significant factor. As discussed in Chapter 4, it is often difficult to obtain information from this population; therefore a larger sample size was recruited to investigate this theory.

IBWC Women

The sample for the International Black Women's Congress (IBWC) consisted of 68 African American women. The mean age was 42.5; the youngest woman was 23 and the oldest woman was 69 (see table 6.2). Data were

collected from 68 women at three meetings.¹⁰ Meetings were held in three locations: Cleveland, Ohio; Newark, New Jersey; and Denver, Colorado. Of the 68 women participating in the IBWC study, only 66 reported their place of original birth. Women were from different parts of the country: 25 from the East Coast; 30 from Midwest; nine from the South; and two from the Caribbean Islands. Most women migrated to other parts of the country at some part of their life.

Table 6.1 Percentage of Women Receiving Mammograms

AGE		Mammograms
Years	%	%
65-69	3	100
60-64	5	100
55-59	10	100
50-54	16	100
45-49	32	100
40-44	17	85
35-39	13	30
20 +	3	0
N=	99	

Women attending the IBWC participated in free listing (N=68), with some semi-structured face-to-face interviews (N=13) conducted. Women interviewed in face-to-face interviews, stated they feel they are treated differently from white women. Women completing surveys at the African American Summit (N=78) did

¹⁰ The three meetings for the purpose of this study is considered one conference

not use the term different. Furthermore, none of the women named racism as the cause for their dissatisfaction with their treatment. However, feelings of “powerlessness” were identified with other dynamics correlating to race factored in to the response.

Free listing was used to elicit the true feelings women hold about breast cancer. Informants at the IBWC were asked in between sessions to list their responses. Women listed their feelings about the word “breast cancer.” They were given approximately five minutes to record their response. Most women listed one to three responses.

Free listing allows the researcher to address culturally relevant domains. It is used in order to quickly obtain many responses in a short period. It is also a non-threatening way to extract information from a cohesive group (Bernard 1995).

Only four respondents did not answer. The other 64 women responded with an array of terms. A total of 144 responses were recorded and analyzed to determine if there was cultural consensus. Cultural consensus is the “typicalness” of a population (Dressler et al. 1998). Women in this study are concerned about death but in a slightly different way than indicated by the literature. Other women described death in connection with suffering and removal of body parts. The perceptions are that cancer truncates and distorts the body in a way that cannot be restored.

Coded responses based on semantic themes were collapsed. Flinn (1988) work with students who free listed reasons for selecting a particular major was

used as the model. I listed the full responses verbatim first. Analysis to the responses uncovered thematic patterns.

Most responses were one-word responses with four complete sentences. I attempted to determine if general beliefs about breast cancer were held. Women responded with expressions of feelings and emotions more often than citing behavior or actions to be taken. The most frequently recorded response from the 64 women responding was death (N=31), followed by feelings of vulnerability (N=23), about having changes to the body (N=20).

The First Response

Responses were grouped into 15 general themes. The grouping was not difficult since many of the women used the same words. The responses were then ranked according to the frequency in which they appeared.

Analysis of the characteristics of the responses determined there was a pattern to the responses. Participants indicated that death (39%) was a major concern. It was the first response 57 percent of the time. It was the second choice 29 percent of the time. Death appeared 14 percent of the time as a third choice.

As figure 6.1 shows women think of death more when they hear the phrase, "breast cancer" than any other outcome. Several women who listed death, equated this with defeat. A few responses included: "death and disfigurement", "people dying", "black women, death and lack of awareness."

Even though the body has tremendous restorative powers when women conceptualize cancer, the majority of the women in this study did not envision these restorative factors. Instead what they see "death and suffering";

"deformities and death"; "death and removal"; "death and breast removal"; death and breast removal"; black women and death."

Table 6.3. Responses to Free Listing Exercise-IBWC Words Used Three or More Times

Rank	Word	Frequency Used
1	Death/Finality	28
2	Alteration of Body/Body Image	15
3	Pain/Suffering	12
4	Fear	9
5	Survivorship	8
6	Friend/Relative	7
7	Symptoms	7
8	Treatment	7
9	Surgery/Biopsy/Mastectomy	6
10	Preventative Measures	4
11	Myths	4
12	Strength/Courage	4
13	Lack of Knowledge	4
14	Depression	3
15	Serious Illness	3
16	Prayer/Religion	3

Factors Influencing Responses

To determine what might influence women's reactions, certain characteristics were examined including education and age. Death was the first reaction for sixteen of the women. The mean age for women responding to death was 45.3. Vulnerability was first among 10 of the women with a mean age of 32.5. Alteration of the body was first among nine of the women whose mean

age was 43.3. Six women had each of the following phrases as a first response 1) suffering/pain 2) options; and 3) family and friends. "Fear" was listed only as a first response among four women and their mean age was 48.5. Twenty-five percent of the women listing death as the first response were younger than 35 years of age. "Vulnerability" was listed as a choice by 94 percent of the women with graduate level degrees. Older women responded to feelings of powerlessness more often than the younger women.

The literature identifies fear as a major barrier to care, however, women did not have strong reactions to fear (N=9). Among African American women according to Dignan et al. (1990) fear and fatalism are dominant, or at the top of their minds as a reaction to cancer based on a study with African American women in Forsyth County. However, neither women at the IBWC nor women at the African American Summit expressed having feelings of fear alone.

Awareness of Mammograms

Corresponding to the responses women showed positive use of mammography. Women at the IBWC did not cite fear of mammograms as problematic. In fact nearly 95 percent (94.8%) of the women participating in the study age 35 or older had mammograms within the last year. Forty-eight of the women participating in the study were age 40 or older. Of the 48 women participating in the study, all but one had (42 years old) a mammogram. The fear discussed in the literature comes from another source.

Ways that women at the IBWC received information about mammograms varied. Women were asked to record why they did or did not have a mammogram. An explanation was not provided by the 42 year old participant

who did not have her first mammogram. Of the 48 women participating in the study age 40 and older 35% reported having a mammogram as a part of their annual check ups. Another 10% reported having mammograms after finding a suspicious lump. Ten percent (8.4%) listed fibrocystic breast and another ten percent listed doctor recommendation. Some of the women (7%) stated they asked for a mammogram.

Thus, African American women's experience in this study does not support the statement found in the literature that African American women are recommended less often for mammograms than white women. Casey, a woman who participated in a face to face interview and followed-up with the interview after returning home reported:

None of us found the lump. I went in for an examination for a very different problem and my (student health), Ob/Gyn doctor did a full exam. I had no baseline information with her. She did an exam. Experience directly contradicts that theory: Nothing. However, to establish some baseline information with her office she ordered a mammogram.

A few years ago the National Cancer Institute and the American Cancer Society suggested women should begin mammograms at the age of 35. Currently, the age for the first mammogram is 40 unless there is a family history of the disease. There were 10 women between the ages 35 and 40. Eight of the ten women already had mammograms. Women below the age of 40 who had mammograms in this study either had a lump or had baseline mammograms as a means of prevention. A 38-year-old woman age summed up her situation.

I'm over 35 years old and am working to address all aspects of my health. I've made a commitment to do the things I need to do.

Overall, women are concerned about their breast health.

Purpose of the Summit

At the African American Summit, the majority of the attendees completed the survey (N=78). Ninety African American volunteers and 23 staff personnel attended. Of the 123 people attending the summit, 76 completed the pre/ post conference survey.

The attendees were mostly African American women. Staff personnel from American Cancer Society did not reflect the population. In fact, there was only one African American staff member. Of the 113 women attending the summit, 76 completed the pre and post conference survey. Attendance at the African American Summit for the invitees had two prerequisites:

1. women had to be residents of the state of Florida.
2. women had to hold a leadership position in a volunteer, community, or political organization in the state of Florida.

It was obvious certain value was placed on the attendees.

The pre-conference questionnaire showed that only 81percent of the women were “very worried” about breast cancer affecting African American women, while 14 percent were “somewhat worried” and 5 percent was “not worried” at all (one woman was not worried due to her religious beliefs). However, at the end of the summit, the number that was “not worried” at all decreased to 1 percent and the number that was “very worried” increased to 86 percent. Additionally, only 83 percent considered breast cancer to be a “very serious” problem among African American women in comparison to women of other ethnic backgrounds prior to the summit. In comparison, 5 percent of the women felt it was “not a problem”, at the end of the summit. Thus, the number of

women who felt it was a serious problem increased to 86 percent and those feeling it were not a problem decreased to 1 percent.

The most significant difference appeared in the responses about the purpose of the summit. Before the presentations were made only 68 percent of the women strongly agreed that the purpose of the summit was to provide education on breast health and 3 percent showed disagreement. Post-summit, 77 percent strongly agreed on the purpose and 23 percent agreed.

The women captured the ways the American Cancer Society works within the community. A large majority, 91 percent strongly agreed that the American Cancer Society organized the pre-conference questionnaire as opposed to a group of volunteers. However, by the end women better understood that ACS works with volunteers. Participants better understood the collective efforts of the committee (99% agreement with organizers of summit) by the end of the conference.

Comments made by the women supported the fact that they felt empowered and a part of that community under the umbrella of the American Cancer Society...You thought of everything..."I have wanted to attend a conference for minorities for a long time."

Furthermore, by the end of the conference nearly all the women (98 percent) agreed that the conference would help them develop a strategic plan in their community so the community can better understand breast health. It is possible that the 2 percent that responded "as not applicable" were ACS employees.

Most impressive was the fact that the women strongly agreed (90%) that the speakers were very knowledgeable about the subject. Basically the summit had a positive impact, 97 percent felt strongly that it was a good idea. Although the survey did not have "scientific significance", women agreed they obtained: 1) new information; 2) new strategies and 3) hope and confidence. The felt empowered. All of the women expressed the desire to have a follow-up meeting that has not occurred in three years.

When comparing the two conferences (IBWC) and the Summit, attention is diverted away from the personal needs of the women at the Summit. The attention appeared to be directed toward personal development and empowerment. When the circumstances are closely examined, it becomes evident that the organizational outcomes are more important. Women at the IBWC situate themselves inside the problem, to look for a solution that makes them vulnerable. ACS staff are situated outside of the situation. A review of the First Response list (see Table 6.2) shows distinct differences between perceptions held by the two groups.

Focus Groups

Three of the five focus groups consisted of all African American women; University employees, the social organization, and the survivors group. Fourth-year medical students also participated in a focus group consisting of eight females; four African American, three white, one Arab female and one African American male. The providers' focus group consisted of five white females and one white (Canadian born) male. The worldview of normality for each group was different from the other groups.

Participants of the focus groups were provided stimuli before discussing African American women and treatment within the medical system. All five groups viewed the same standardized case between a standardized patient [an African American woman] and provider who informs the patient about her diagnosis of breast cancer. The following similarities were found between women and providers. Both women and the providers expressed feelings of powerlessness during encounters because of the lack of understanding between the two cultures. One woman specifically stated:

They [providers] don't speak in "our" language, they speak in, "their language." They talk down to you ... you cannot understand what they are saying to you. Plus they don't tell you everything. Information is withheld due to [our] race. They tell white women more about what is going on than black women.

This message is consistent with the themes found in the focus groups. Themes were drawn from each focus group. Having information withheld was one of the themes from women who were never diagnosed with breast cancer. Other themes are listed consecutively because they were in some ways a continuation of one thought pattern. Unfortunately, it was not until the end that the groups were afforded the opportunity to communicate outside of a short encounter to one another to appreciate the shared feelings of powerlessness.

Women had messages they wanted communicated to their providers consisting of six themes:

- Not enough information is provided
- Because of race, black women suspect information is withheld
- Black women seek out person(s) they can trust to obtain information
- Daily responsibilities are not considered
- Women are frustrated by stereotypes (race/class)
- They know people, who have survived cancer, so they know it is possible.

Providers themes were slightly different. They had interesting messages they wanted to communicate to their black patients but did not know how. Providers:

- feel a responsibility to the women to provide scientific knowledge (instead of the humanistic response).
- feel they must have the "scientific answer".
- don't know what to do in response to the heavy burdens placed upon them with the health disparities.
- are not aware of many of the myths
- do not recognize how empowering myths or prayers can be.
- are at a loss on how to get African Americans to trust.
- welcome help and support in dealing with culturally sensitive issues.
- are frustrated by stereotypes (gender issues
- have feelings of inadequacy much like their patients
- do not want total responsibility for decisions
- prefer a team approach with the women, who are the owners' of the body.

Medical students were most aware of the problem racism cause. Women in this group spoke openly about differences. Medical students say they:

- recognize their power and want to empower their patients
- are open to praying with patients
- feel the lack of trust from patients
- recognize the need to address class, race and gender issues but are not provided with the training
- have patients who look to them to answer questions after the doctor leaves
- are overwhelmed by the responsibility to be the, "trusted agent"

Differences in Perceptions about Illness

Communication is a problem between patients and providers. Women are not aware of the concerns of their providers. They interpret provider's responses as marginalizing their feelings when they try to explain their concerns. Three survivors in the group of seven survivors recalled what their providers told them: "it's nothing." As a result, there are poor outcomes.

Rita, a survivor explained what happened when she went to see about a lump in her breast the physician said: "It's just a fluid filled cyst; let's watch it for a couple of months." She further explained.

When I went to the general surgeon, I was shocked by the news I got from the general surgeon. He just said, "This doesn't look good". By the time I was diagnosed, I was in stage II. I don't think it was race because; I've talked to white women who had the same results.

Women expressed apprehension as opposed to a lack of knowledge as cited in the literature. The reason is attributed to what one woman never diagnosed with breast cancer stated, "Doctors misinform us about our situations."

Evidently, black women do not feel comfortable asking questions about health. When they do not ask questions assumptions are made. The behavior of women who choose not to ask questions is misinterpreted to be avoidant or noncompliant. During the focus group one of the health care providers posed a question demonstrating the level of misunderstanding.

I have a woman that came in that needed treatment. When she does not show up she states I have to take care of my grandchild, I can't come back because I have to take them to practice. Is practice really more important?

Analysis of the message from this patient's actions is: "I am not the priority in the family, the next generation is important." This is a common cultural theme by

black women (see Chapter 3). African American women are the great sacrifices for their families, especially when it comes to their education, nutrition or their health. In nearly every situation, they put others before their own needs. Black women, who watched their ancestors work with limited resources, learned their words and deeds become the source of power within the family.

As a mother, you do so much for other people that the last thing you want to hear is that you are sick. Who would take care of them while you look after you there's no one to look after you.

Another respondent a mother of six daughters stated, "You don't feel so important that the world should stop for you."

Providers in the focus group expressed feeling "powerless" during the encounters because their view of the prescription of the physical reality of the disease differs from the patient (Baer, Singer and Susser 1997). The physical reality for the provider is that a lump, if detected early, can be treated. Early detection is the key to survival. Contrarily the physical reality for the African American woman is more humanistic than biological. Providers are taught to feel responsible for giving the scientific answers. Women prefer the humanistic response:

Will I be able to care of my family? How much time do I have to take off from work? Do I have to tell my family or friends? Can we keep this a secret?

The general difference in realities is twofold: to the provider, it is the biological malfunction; for the woman breast cancer is associated with a moral form of punishment. Knowledge of breast cancer is interconnected with negative behavior, as evidenced by the high number of women responding at the IBWC by listing fatality, suffering and pain in their responses rather than variables such as

survivorship, treatment or prevention. Women rarely listed symptoms (N=6) or emotions (N=6), such as anger, courage and grief. Surprisingly, even prayer (N=4) and myths (N=4) were among the items listed the least often. This finding differs from that in the literature.

Fear is the major emotion. Fear may be the product of helplessness and powerlessness. To effectively analyze fear associated with disease, the origin and basis of the internal and external stimulation to the feelings must also be examined. For this study that meant asking, "What are you afraid of?"

Identifying the Problem

Among providers the physical realities are biological and environmental risk factors not social and political risk factors. One of the women in the focus group explains it, "If you name it, you claim it" These realities haunt the African American woman.

African American women have a difficult time deciding if it is their race, their gender or their concerns that are being marginalized. Here symbolism is used to show that women associate the different levels of health care (see Chapter 2) with power. Casey who was interviewed at the first IBWC described her mammogram experience;

"It's particularly overwhelming where the fifth largest employer in the town is the university, with one of its largest divisions being the huge university hospital system, which heavily advertises itself and builds its reputation on its name. It is a physical environment that almost makes one feel like cancer is being created and made to market."

Casey indicates how African American women use their intuitive feelings to interpret how to negotiate powerful systems such as the medical system:

My visit to the place frightened [creeped] me completely [slam] out. Even from the very first visit. For any woman, but particularly women of color, who tend to nurture their intuitive, psychic side...

How does such a psychic encounter affect them mentally and physically?

I felt something thick in the air. How much of it was my own personal fear about cancer and how much was, "itself" may be debatable, but it was really clear to me that most of it was something I was stepping into.

The feelings of powerlessness come from the combination of unfamiliarity's to the African American culture. For instance, the structure of the facility makes an everlasting impression: Casey explains

I went to the Cancer Hospital, a brand new tall [probably the tallest on campus], neo-classical building, very new, modern, plush, full of creature comforts and totally strange [weirding me out]. I am not a usually eerie [weirded out] person. I describe myself as physically thick headed. However, the place raised the hairs up on the back of my neck and had me snarling like a wolf about to go into a fight to the death posture. The place felt like a 'living, evil thing' as though a temple was built, a temple for a demon to live.

Casey ends with this metaphor...

"Come willingly, blindly and filled with trust so I may feed on you.

This is what Casey thinks will happen if cancer is found in her body. She explains that a living entity will invade the body and the demon will live inside consuming her totally. Symbolism is used to show the building goes from a temple, to a demon to the source of power. Control gets transferred from the woman to the building or those who represent the building.

Casey is completing her graduate studies and provides a more critical account of the experience than most other women in the study. Her explanation points out a clear discontent with having to go to such an unfamiliar location. Her description indicates that power and domination are not disguised.

The use of metaphors to describe the particulars of the building illuminates her feelings. The building stands for deception and evilness amplifying her fears. Casey explains why she is so fearful

As I approached the building, as I walked inside and through the building, I felt like I had to put up some type of defensive shield or wall. I felt like I had to fight back some kind of force, demon, something. The place, despite its newness, being plush, with prompt appointments, skylights, plants, etc. felt like a place where people were brought to be sacrificed. I thought, "This must have been what it was like to have been brought to the Aztec sacrifice mounds, "Weird."

It is interesting that she used the Aztec example to show sacrifice rather than an example from the middle passage, the African American experience. Casey relates her experience to a notion that is demoralizing and sure to end in death. In addition, her description of the experience demonstrates the powerlessness of an oppressed population.

Scheper-Hughes' (1998) in her work states it is important to focus on the relationship between the body politic and the environment. Critical medical anthropologists recommend taking a critical approach to examine individuals' responses and the surroundings. For African American women the previous health care experiences must also be considered as the cognitive appraisals of those things she identifies as powerful.

Casey conceptualized the body as being subjugated by the institution of biomedicine. She perceives the building to be deceptive and corrupt. So she must combat two elements: the powerlessness against the disease that may destroy her body and this paradisiacal facility and those that represent the institution.

The facility is supposed to convey that sense of well-being, nurturing however in her mind it has a paradoxical effect of gloom, doom, and death. Casey describes a gorgeous structure created to give the ultimate in care instead it intensified her overwhelming feelings because she cannot identify with the ways in which the different components will contribute to her well being such as plants. In fact, her comment about the Aztec makes it seem more like a funeral than a place for the living.

As Casey demonstrates the character of the facility represents the ultimate in power. The contradiction for Casey is not just with the illness but with her social positioning as well. Casey feels profiled, recognized as the inferior sex, and lesser race. Saddled with this profile, if her life is threatened by this dreadful illness she is not guaranteed adequate treatment when placed in this state of the art therapeutic environment. This could be the end depending upon what the results are and how much power the demon use against her.

The level of education or the socioeconomic status is not the dividing line for where the African American is situated. In Jeffers (1997) study an example is provided of what a physician [psychiatrist] between the ages of 45-54 does to maintain power while receiving the results of her biopsy from her physician. Women who are in positions of power experience problems. Dr. Sadhana explains:

I forced my physician to give me the results over the phone so that I could respond in private. I called from home, not the office. I knew I could not show weakness... This was my colleague...I was pretty well known in the medical community. I was even on the board of admissions for the medical school. At some point my cultural beliefs surpassed my medical knowledge. After he told me I had cancer and needed surgery I told my physician we

would have to wait [a few months] for my surgery [until she got her patients settled].

The motivating force for the delay was:

Although I had covered for my colleagues for over 20 years, I was not one of the good old boys. I had an established practice that I worked for over 20 years to get. There was no one to take over my practice so I had to wait to get my patients situated before I could have my surgery.

Physicians are products of one of the most powerful educational systems in society. Society has allowed medical education to shape attitudes, beliefs, behaviors and values about race and sex (Henderson et al. 1997). Since white males dominate the medical profession in the West, it is they who are socially positioned academically and economically in the top half of society at the opposite pole of the black woman. It is they who determine how the medical culture will accommodate those seeking treatment. Medicine is a narrow culture focused on the relief of pain, and not cultural or social issues (Perkoff 1997).

When cancer strikes an African American female physician, her profession is minimized. She feels the threat as an African American, a female, and then a physician. Threatened with breast cancer she seeks grounding from within her cultural beliefs. Dr. Sadhana explains how she found herself resorting back to cultural beliefs for support. To understand how frightening it must be for the average black woman not trained in medicine, it only takes looking at what Dr. Sadhana experienced as an African American female physician. She explains how she retreated to her home to find her source of power and grounding when she received her diagnosis rather than getting the news in her office where she spends about 80 hours a week.

From home I was catapulted into action. After receiving everything, digesting it and even being able to cry in the safe space of my home, I was catapulted into the action of planning, asking for what I wanted, notifying my patients, getting finances in order, even purchasing my grave plot, etc. Although I am a doctor and I knew all of these things [intellectually what had to be done], I still had to rely on my culture to get the things that I needed. I don't care if you are Jewish or what you are you return to your culture during a time of crisis.

It is interesting to note that she did not feel her power came from inside her office where she spends most of her time.

There is interconnectedness between the social and political factors that cause feelings of fear or powerlessness against breast cancer (Green-Powell 1997). Stating that fear is a predominant cause for delay by African American women does not give insight into the cause of fear. It must be determined how to associate the fear. Dr. Sadhana tells of the fear or isolation:

I had a colleague also diagnosed with breast cancer, who was an Asian Pacific Islander. I helped her prepare for her oral boards. After she had these successes she moved away to a more remote area, so she didn't have the same support system. During treatment being away from her cultural environment and her support system of the medical center added to her depression. Having breast cancer further isolated her. She had no way of simply reverted to her culture and the next thing that I heard was that she had a fatal accident; a truck hit her.

Death for those who cannot find grounding and a source of power may seem like the only way out. Even for those trained in the field, the unconscious depersonalization of medicine can be devastating (Perkoff 1997). Other women find grounding in a way that helps them defend themselves against one threat at a time.

Denise participated in the last survivors' focus group, and it was the last time that we got to speak at length. When she explained how she received her diagnosis she states

I was initially diagnosed with breast cancer in my early twenties. The doctor didn't think I had breast cancer at first...He said I was too young. I was treated and went on to get married and have two beautiful children. I've had two more episodes with cancer. I went into remission and came back out.

When asked why they denied she had breast cancer, despite having a family history she only replied.

I have a beautiful relationship with my doctors and they have taken good care of me. I have a good God too. I really cannot complain.

In response to whether or not the women had support, Denise shared that her family had not seen her break.

I do my crying in the shower.

For some women it was difficult to speak of being racially profiled although they give accounts of being told to come back, or "let's watch this". Denise never spoke negatively about her treatment in the group. She never showed weakness. The words, "I have cancer all over," came in the midst of the conversation during the focus group. Losing control is a major concern for the women. It took several reviews of the tape to capture that statement. Denise's interview was to continue when she returned from her New York Christmas vacation, except that was Denise last vacation.

Denise was one of several women who had breast cancer who did not identify racial profiling as a problem. Perhaps it is because racism appears to be uncontrollable. Still, the need for special treatment was verbalize and they agreed black women have special concerns. Nearly half of the survivors (10) had a family history of breast cancer. Still, in several of the cases they felt the doctors did not aggressively approach the lump on the initial visit. None of the women had a black provider.

Overall, the message the women want to convey to the providers is to listen to what they are saying when they present with a lump. They also want providers to show concern when they present with a lump, especially younger women. Mrs. Gray states,

It might be their 500th time to see this [a lump], but it is our first time, they need to remember that when they are talking to us.

The data shows African American women between the ages of 40 and 44 have an increased chance of dying (33.2 versus 19.7 per 100,000) from breast cancer when compared to white women according to the National Cancer Institute. Moreover, younger black women between the ages of 30 and 34 are two times (7.7) more likely to die from breast cancer than white women (3.8), according to the National Cancer Institute. Several women gave evidence they were treated differently initially.

Denise like Momma G never said she was racially profiled, but as an anthropologist I made an observation. She stated during the focus group, "I am out of remission for the second time; it's all over my body". I later learned from someone very close to her that, she did not believe she was going to die from breast cancer. What message did she receive and how did she get that message?

At the first focus group Pat, who was never diagnosed with breast cancer, shared why messages may be confusing for women. In response to the question, what do you think is the cause of some of the communication problems between black patients and providers she enthusiastically came back with,

They [providers] don't speak in "our" language, they speak in, "their language". They talk down to you ...you cannot understand what they are

saying to you. Plus they don't tell you everything. Information is withheld due to [our] race. They tell white women more about what is going on than black women.

A major difference between the survivors group and the focus group with women never diagnosed is that the survivors rarely spoke of being racially profiled except Donna who volunteered to participate in the study. She was interviewed while waiting for test results... after receiving a diagnosis the year before. She specifically complained about the way the doctor spoke to her.

I could hear the doctor next door and how he was talking to the woman in the next room. He seemed to be very nice. I knew something was wrong because they kept making me come back and I had to wait. I didn't like the way they were so secretive with the information. This was my body and they would not tell me what was going on. I remember clearly when he came into the room. He was Indian [East]. He looked at my breast and said, 'Oh my God, we have to cut it off. We have to get rid of this thing. We have to do surgery now.' [Imitating his accent and mannerisms.] He didn't talk to the woman next door like that. I was in a daze. I got dressed and walked passed everybody. I just walked out [of the office]. If I had of passed a bridge on the way home I would have driven off the bridge.

Her breast was so enlarged; the weight of her right breast caused her to lean forward in the chair on that side. Her current provider was able to convince her to take radiation therapy, have her surgery and she is now in follow-up care doing well. Donna's reaction is identical to the reaction of Preacher woman (Mathews et al. 1994). They left the doctor's office and did not return until late stage, or they had no choice.

Rita was in the final survivor's group. She does not attribute her problems to biomedical racial profiling either, but she shares a story similar to other women,

When the doctor told me it was just a fluid filled cyst "I had to insist" he do further testing. I was in stage IV by the time we caught it. Then he just wanted me to give up and go home and die. I had to find the places to go to for further treatment.

The survivors appear to have loyalty to their professional team. They show tremendous gratitude for the physicians saving their lives. In fact, most categorically defend the relationship established with the oncologists and surgeon. Therefore, they are reluctant to identify racial problems. Probing reveals racism is in the background of their mind.

Mary, who sits quietly at the head of the table, still in her scrubs from working that day denies having any racial problems in the beginning of the focus group. After sitting quietly for approximately thirty-five minutes she shares when her experience,

"I had a problem with my doctor at first." She does not look up but raise her eyes to look directly at the white male researcher who was behind the video camera, videotaping the group. That is the signal to the women sitting around the table, that the provider is white. "He did not want to treat me." She continues, "but I knew how to handle him. He was the best [doctor] so I worked with that problem [racial]."

The nonverbal communications of the women indicate racism is folded into the problem. Also folded into the problem is the issue of control. Control is what women fear they will lose.

Diane, an attorney, a sixth month survivor, says, she

had no doubt about survival. I had to take control.

Helen, who was very soft spoken, petite and gentle, explains she was young, under 40 and did not know what to do.

My Aunt brought me through, she gave me the advice on what to do, which questions to ask, how to make it.

Pauline, a research assistant in a cancer lab stated:

I watched cancer grow everyday in a lab and I could not believe this thing was growing in my body. I knew I was going to do whatever I had to get this thing out. I told everybody. Everybody I knew provided support. We

prayed., we did everything. I told my doctor we need to take care of this right away.

The fear is the written about in the literature appears to be connected to fear of losing control (Wardlow and Curry 1996). What is common among the survivors' stories and throughout the literature is the need for control and conservation of power for survival. Racial profiling is in direct opposition of the concept of the individual having power or control. Studies show African American women use prayer as one source of power (Erwin et al 1996, 1999, Mathews et al 1994). This work also shows survivors were assertive about taking back their bodies.

Focus on the Message

In reviewing the reasons for delays for screening and treatment attention is devoted to those factors that influence power and control over the woman's life. More to the point, women point to the subtle messages transmitted at every level of the health care system. First inconsistencies appear in the system. At the individual levels of the social and biopsychosocial relations of the health care system (physician-patient/interaction) being sick, or ill, or incapacitated, but being, "out of control", being powerless. life have not been explored. The response to whether how much force is used to correct the crisis the individual finds himself or herself a part of is based on social status, educational level, and race. , The extent to which the women considers the problem significant compared to the extent to which her provider considers it significant must be agreed upon. Race appears to be the wedge. The survivors message is clear- Nothing will stop us! National organizations struggle with the message to send. The message at the IBWC conferences focus on the systematic approach to

health care. Discussants place emphasize on the precursors to serious illness, such as stress; anger, anxiety, depression and spirituality, to explain how these behaviors affect the chemistry of the body. IBWC acknowledged that to have discussions about health without acknowledging the impact racism has on the black population is a travesty.

However, women at the IBWC are in a “safe” place to have scholarly discussions about their body. Consequently, interwoven in and out of the discussions on health are various ways negative social factors affect not only the body but the lives of black women. The message comes not from a racist, feminist perspective, but from a public health perspective. Preventable illness gone untreated is costly to the medical sector. The message is an educational awakening to enlighten women and their health care providers.

The women in this study know that solutions to health care problems are closely connected to the social worth assigned to their bodies. This is why they feel they are racially profiled in America. The short statements added to the free listing and surveys is further evidence of their fears:

“I feel fear, will it happen to me?” stated a 48-year old at the New Jersey conference.

“What decisions will I make and will I make the right ones if chemo or radiation or surgery is said to be necessary,” stated by a 42-year-old New Jersey woman.

“Please God, save me from this, from losing my breasts”- a 39-year old doctoral student stated.

Women in IBWC combine intellect and emotion to respond to the question. However, women from African American Summit, have no representative. Is the American Cancer Society, their representative? Early in this chapter, I make

mention of the fact that there were few minority employees from the American Cancer Society. In another location where focus groups were held I continued to do volunteer work over the next four years where, they never hired an African American. What happened is that it brought about discontinuity between the agency and the volunteers. The focus shifted away from the illness and back to the political economy of health.

Political-economic approaches focus on the difference in distribution of power (Baer, Singer and Susser 1997). In my work (1998) on ethnic amplifiers, I discussed how certain barriers to screening and treatment among African American women become verbal and nonverbal cues. These cues amplify the real or perceived struggles for patients reminding women of their powerless position in society. I emphasize the struggle that takes place between patients and providers in asserting their power. Understanding that both patients and providers possess prejudicial attitudes that elicit a certain type of response in both groups, it is important to recognize the asymmetry in the power relations (Baer, Singer and Susser 1997) noting what each person does to defend their position.

Again comparing the African American Summit, at the Summit they preached early detection and increase in support groups in the community as forms of control of the body. Early detection and support groups are major concerns because they can help empower black women. Clearly all women want to be empowered. Again, I point to Foucault's (2000) work on power and his concern about tactics. What are the used to get these support groups? The

relationships established between the women are one in which the black women work as volunteers for the American Cancer Society. Few dollars are put back into the community. In fact, the volunteers are expected to do fund raising which means extracting money from the community. The organization does not put power into the community. The organization maintains control of the state of affairs because all decisions come through the organization. Now, I can hear Casey a little clearer citing deceptions that caused her to be fearful of not only the building but also what it symbolize.

I do not believe it is the intentions of the agencies to deceive women or to maintain a relational character of master/slave or inject a superior/subordinate power relationship upon African American women. The Director of the African American Summit, approached this project objectively. She is sincere in wanting to see improvement. In fact, during and after the Summit she voiced concerns about the relationship African American women have with the organization because she wants to see cancer eradicated. Consequently, she has taken trips to different areas around the state to look at programs first hand. It would be creating a gross misunderstanding if I stated all organizations and agencies intentionally enforced power, control and practices upon minority populations so strict that they cannot become empowered. It is also unfair to state only black organizations can provide support to black women. Neither one of those statements are true. What is true is there is a culture of resistance among black women based on the fact that power is acquired, seized and shared (Foucault 2000). In order to transfer that power to black women (or use the term empower

them) so they can survive, racial profiling must be acknowledged. Until that occurs, not only is the woman powerless against the disease that may be destructive but she is also intimidated by the place she has to go to in order to find out about the cancer. The woman, her doctor and the agency are all victims of racial profiling until this change occurs.

Conclusion

Meaning has not been attached to the prescriptions for behaviors that connect profiling to race, class, and gender. Health promotion activities directed toward African American women usually do not take into consideration the long dark road they have traveled. In order to have the capacity to engage in the proposed programs, acknowledgment of not only the beliefs, but also the struggles must take place. The message the women sent is not one of pity, or shame, or guilt, but one to ask for acknowledgment that a problem exist. The voice that was heard the loudest and clearest was the one that states, health care can be better performed if profiles are adequately addressed so that all persons may receive appropriate care. In this capitalists society, if nothing else it will be more cost effective.

CHAPTER 7 ELEMENTS OF BIOMEDICAL RACIAL PROFILING

Introduction

The cause of the fear black women of receiving screening and treatment for breast cancer is directly related to the identity of the woman. It is true, black women have tremendous fear of fatality, because of who they are. Their previous life experience affects how they approach screening and treatment. Women have been profiled and labeled; both are discussed in this final chapter.

Overall, this work interprets the meaning of screening and treatment in relation to previous life experiences. Failure to participate in health care a practice is based on mistrust in hegemonic treatment modalities such as historically produced disproportionate suffering and pain for black over the years. Now what women negotiate is how to suffer instead of whether or not suffering will take place.

There are five elements that must be measured to determine if biomedical racial profiling occurs in a system. To determine if it is occurring an analysis of each one should occur. The way to overcome this obstacle is through education that will be discussed at the end. Each element can be addressed individually or collectively. They should be considered in all health related programs and used to measure whether the program is meeting the needs of the program. The five elements are :

- Does the system identify individuals according to a certain profile?.

- What are the ways their health care problems are connected to race or color
- How do their traditional beliefs and attitudes impact their ability to seek care? How are they marginalized compared to the dominant culture.
- What is the assumption about suffering for this population?
- What is known about the life experience of this population as it relates to this illness, disease or procedure? .

In previous works (1998) I identified these as ethnic amplifiers. The argument now is that in order to improve upon the efficacy of screening and treatment programs, these issues must be addressed at each level of the health care system (see Chapter 2). To destroy ethnic amplifiers, or any biomedical racial profiling patients and providers must know how to negotiate this barrier to care. It is also the ultimate responsibility of the provider and patient to understand one another.

Failure to Identify the Problem

The first element is crucial. We tend to fail to identify the real problems associated with a black patient. This problem has not been addressed in health because research does not consider how black women were labeled once they entered the country or the effects it has had on future medical care. In order to understand how "black women became one of the most devalued female groups in American society" recipients of a male abuse and cruelty that has known no bounds or limits (hooks, 1981) certain information must be shared. It is noteworthy that cultural competency programs are being instituted in the health care curriculums but as a physician recently pointed out , does this mean white

doctors will have ethnic equality or ethnic realities?. Cultural competency does not address the issue of power!

The point to be made here is there has been a strong focus on depersonalization of Black women directed towards their sexuality. Some of these labels silenced black women for many years. In much of bell hooks work on race, gender and culture she mentions how the media and literature use propaganda to keep women silenced. Who is Aunt Jemima and what does she personify in the main literature? asks hooks. She among other black feminists explain how labels have become badges during modern times for women. Some of the badges attached to black women include: mammies, matriarchs, Sapphires, Jezebels, caregivers, and field hands (Mullins 1997, hooks 1996, 1995, 1990, Wallace 1995). Those in positions of power engrave these badges into the souls of black women. Blacks scholars argue, women have neither portrayed these roles nor identified with them, so how did they get these labels? Yet, they treated accordingly. African American women were assigned specific political positions and labels designed to assert power and control. These assignments cannot be ignored because treatment is administered to coincide with these roles. They include:

Mammy

Michelle Wallace calls her, "the ideal slave an ideal woman". She is "obese, domesticated, asexual house slave with a world of wisdom, the patience

of Job, a heart of gold and the willingness to breastfeed the world.¹¹" (Wyatt 1997). Full-busted, asexual and maternal (Roberts 1997). According to Roberts, she is sanctioned to, "talk to the Lord", to pray for others. Still, credit is not given for parenting her own children. Presumed to be dark-skinned, the woman assigned the role of Mammy is not viewed as a threat, to anyone (Wallace 1995)

The role of the Mammy is the most overtly popular role among older black women. Black women assigned the role of Mammy sacrificed for all. The Mammy is often the advisor, the nucleus of the extended family system. Nevertheless, her wisdom is not recorded in the literature (Wyatt 1997). Additionally, her role as educator, is also ignored although once she is educated about something, the entire community becomes educated.

Jezebel

The evil black woman, considered dangerous, she can be spotted by her attire; bright colored, tight fitting clothing. A seductress, she is not to be trusted because she has no morals. (Wyatt 1997). Perceptions are they feel no remorse for what they do and how they do it. They are the initiators of sex, receiving what they deserve, even if it is rape, are the feelings expressed by one woman (Mullins). Jezebels are the polar opposite of the Mammy, according to Wyatt (1997). Her emphasis is on sexuality and material things. She is known because "her erotic and sexual prowess led men to wanton passion" (Roberts 1997:12).

11 To understand the metaphor being willing to "breastfeed the world" it is important to look at the historical meaning of big breasted to women of African descent. The breast is directly related to the woman. Slave value of black women were often responsible for breast-feeding their babies, the babies of other women [if the woman was not available, i.e. death] as well as slave owners children .

Women who are labeled as Jezebels, usually receive this label shortly after menarche. Wyatt stress that in order to be a she-devil a woman has to have very poor self-esteem or self worth. Unlike the Mammy, the Jezebel is openly discussed. Two examples found in the media are

Stereotyping black women as Jezebels, justifies the perceptions that she is incapable of being a good mother as she has no morals and is not a good role model (Roberts 1994). She can be sacrificed.

Workhorse or Field Hand

Wyatt describes the workhorse as the gender-free woman who excels through hard work, and backbreaking skills. She is the "strong black woman" who can withstand anything, physical, emotional or psychological abuse to include rape. She is believed to be able to rebound. In the new millennium she is the well-dressed, executive black woman who is salaried, housed, well spoken, who is often childless and alone. The image she portrays according to Wyatt is to avoid "feeling vulnerable, powerless or dependent upon a man."

Strong Black Woman

There are two different images of the "strong black woman". Terrelonge (1990) among others describe the perception that a primary role of the black woman is to unite blacks. It is the belief that this role should surpass all other roles.

Welfare Mother

The welfare mother is the she-devil who is being paid through the system. Roberts work shows that in 1990, 78 percent of white Americans believed that Blacks preferred to live on welfare.

The attitude prevails, that black women hold these profiles. During the Lifting While We Climb study (Jeffers 2001), a project designed to provide free mammograms to rural African American women with limitations, a white woman who pretended to be African American over the telephone the telephone during screening by director, an African American woman made it all the way to the clinic to get the free mammogram. When she was contacted again by the director she complained that

"n----- get everything" (Jeffers et al 2002, Jeffers 2002).

Her complaint was among several received during the two and a half year study. The perception was that blacks are lazy, shiftless and looking for a hand out. According to Roberts (1997), the media has taken advantage of the most extreme cases to demonstrate how irresponsible black "welfare mothers" are despite receiving assistance. The traditional values are to ensure women do not fall into being labeled one of the above.

The True American Woman

From an afrocentric perspective, Mullins states, the role of "an American woman", is primarily defined in relation to love. "Love", American style may be problematic for blacks, according to Cornell West (1994) because "... black folks cannot love themselves." That is because of the amount of hatred placed upon them at every level. Even when they try, someone complains.

Until now the implications have been that all women living in America fulfill the same role expectations as other women but Rosser (1994) feminists explain the impossibility of this accomplishment. The data shows African American women strive to claim their identity by moving in between the roles of their

African Ancestors and that of the American woman, which they may never achieve. hooks (1981) works accuse the Colonizers of resorting to labeling as a part of projection and transference of feelings they held about blacks.

Accusations that black women were promiscuous were in response to savage sexual exploitive attacks. In fact she finds the Colonizers in contempt for using the black woman's body as their, "sexual latrine" (1981:33) only to have white women believe the men had to only succumb to the advances of the black woman.

The argument that black women in America are subjects of biomedical racial profiling comes on the heels of feminists work such as hooks which relates that the identity of black women was "socialized out of existence" (1981:7). Traditionally, the identity of the black woman was part of a group without a positive individual identity; being black meant being a part of the black male or being a woman a part of the white woman interconnected her. Her crowning moments which came about with the civil rights movement was announced and named the arrival of the, "Strong Black Woman". As bell hooks, Patricia Williams, Patricia Hill Collins, Leith Mullins, Irma McClaurin, Cheryl Mwaria, and other black feminists articulate, that is a label with deep structural meaning. The label has connotations of giving those in the dominant culture permission to continue the oppressive acts. A final statement on these roles, these are not the values of black women or roles they acknowledge.

The historical process used to create race and engender women must be included the lessons on treatment of patients in medical school. In turn patients

must have provisions to understand foreign-born doctors. Therefore educational programs must be provided to help patients and providers understand how identity is constructed politically, economically and socially positioned in society and impacts decisions.

Connecting Race, Status and Treatment

Personal perspectives of black women that describe their background information describe reasons for their delays in seeking screening or treatment. The ways this relates to breast cancer has not been recorded in the medical literature. A clear connection is not made between race, status and treatment. The way power determines treatment is downplayed in the medical literature. In Chapter 2 the levels of health are outlined. The power does not flow down to the patient. Blame is projected on to the patient for not caring enough for their bodies when they do not come in for treatment.

A review of Chapter 6 shows, they care the best way they know how under austere conditions. The women are labeled as inferior, further weakened and dehumanized, unsupportive political, economic and social systems. Then they have to try to negotiate a racialized, medical system. A suggestion is to implement more programs with corrective actions such as Sister's Network and The Witness Project® to empower the women, rather than using the power against the population. Have these programs act as umbrella organizations connecting with American Cancer Society and larger traditional organizations. Sister's Network and The Witness Project can provide training to the American Cancer Society so they no longer profile their clientele. One way to find black

consultants is to seek out organizations like The International Black Women an organization filled with academicians.

Ignoring Traditional Values

A problem found in the literature and during the study is that the majority is persuaded to believe that black women are inept in their beliefs and practices. Ignoring traditional values is one way the majority devalue black individuals. The traditional values from African societies are ridiculed first (Mathews et al, 1994) and then ignored by the majority. The “folklores” were reduced to attitudes, beliefs and behaviors that are now regarded as barriers to care. The story of black women as caregivers is told in *Wings of Gauze*. It is said that, despite black women having a long history as healers, at the beginning of World War II the role of white women increased in public health and nursing, environmental health, health administration and epidemiology and black women were moved to the background. Black women, even with formal training as doctors were given the last assignments. For black nurses, that often meant remaining in her community and continuing to do domestic service (Himes and Thompson, 1998).

Even the strongest indigenous medical practices of blacks were not mentioned as good or bad. They were simply ignored. Black women were not made to feel worthy of being a professional or receiving professional doctor's care. So they continued to rely on their own remedies, which they passed on for generations. The women who remained midwives were challenged and labeled by credentialed professionals as, “the typical, old, gin fingering, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers full of

dirt, and her brains full of arrogance and superstition..." or "a filthy and arrogant and not removed from the jungles of Africa" (Salk et al; 693).

For hundreds of years, black women used traditional medicine in response to the limitations and barriers brought on by racism. They provided care to both blacks and whites. While western medicine may lack documentation about this period, black women's old tradition has kept this part of their history alive as well as keeping many people alive.

Superstitions

When blacks provided treatment that whites did not understand it was attributed to superstitions. Superstitions were put into place for protection. Negative influences are powerful actions against this population. Providers must understand their purpose. The belief still exists that the etiology of disease is either something that is caused from the environment or something that is caused from the person being from the will of God (Snow 1981). So a shift to a lack of harmony between a sick person and the environment is cited as the cause of illness (Dubos, 1993). It is not uncommon to hear of "bad or dirty blood paradigm" (Mathews et al 1994). This was routinely heard throughout the focus groups.

This was not an abstract concept. The association of a lump is related to certain natural process was passed on for years. A lump in the breast was not considered an illness because "knots or lumps would come and go or move around the body". Also, boils on the skin were known as risen or whiteheads. "Boils came from impurities in the body, these risen came up in order to get out. Lumps on a body were caused by bad blood." This information has been

recorded in Mathews et al. (1994) study and is believed by women throughout the south. The form of treatment was not surgical removal of the lump it was the natural process that would take place over time (Mathews et al. 1994). In their study, Mathews, Lannin and Mitchell interviewed twenty-six women in eastern North Carolina all with advanced stage cancer. The study showed that for “the majority of these women, cancer is a taboo topic to be concealed by others even family and friends” (Mathews et al. 789). Over half of the women (16) in this study thought the lump was from a bump or a lump. Nearly all of the women (24) associated the characterization of lumps with a living thing such as kernel “under the arm” or something “rooted” in their breast (Mathews et al. 1994). At least twenty of the women believed that the surgery would be too dangerous; they felt that just leaving it alone would take care of it. They believe that “the cure is worst than the disease” (1996). Dignan’s (1990) work with African American women in North Carolina showed that “fear fatalism was clearly dominant, top of mind reactions to cancer”. Part of what supports superstitions is the long history of poor outcomes. Cancer stories with positive outcomes were rare. The disease is regarded as having anything other than good conditions.

Is Race The Real Issue

There is data that shows that the barrier to care is culturally based. Perkins, Cooksley and Cox (1996) did a study using ethnicity alone as a predictor of five survival rates using univariate analysis finding that the mortality rate for black females was higher than it is for white women. Of course when they included all factors, socio economic states and treatment, they found that ethnicity was less significant. However, the surveillance, epidemiology and end

results (SEER) percentages for the periods of 1986-1992 also show a difference in the survival rates with ethnicity as the reason for the difference. Until women are able to see the difference they will believe race is a significant factor.

Providers must become aware of the impact this has on their patients

Profiled To Suffer

The fourth characteristic that blacks are poor and uneducated about disease, therefore they make good subjects is a serious concern in the black community. The message here is that blacks are profiled to suffer this level of racism has deep rooted effects. Feagin and Sikes (1994) works shows how racism leaves generations of scares, because it is not an abstract concept, it is a lived experience. Populations with continuous poor life experiences tend to avoid establishing a relationship with that sector that causes these experiences. They hold on to their traditional beliefs. If a structural obstacle of ethnic amplifiers such as racism still exists in health care, why would black women expect to receive better care?

Isolation, Suspicion and Fear

The inability to trust promotes isolation, suspicion and fear. Byrd and Clayton (2001) among other researchers show that historically major diseases for African Americans have been fatalistic. In recent years, it was discovered that even when a cure existed for a disease, there was no guarantee that it was passed on to African Americans. The government recently had to acknowledge that when blacks volunteered to participate in a study on syphilis they were given inferior care and misled about the care they received. (Byman 1991) Fear becomes overwhelming for the population as a result of these actions.

Tuskegee Study

The unnecessary death of a large number of the 399 men observed by the public health department in a study conducted in Tuskegee, Alabama from 1932 to 1972 is still fresh in blacks minds. The men were rural, uneducated African American men. The public health department initially employed a white physician to lead the study and a local African American nurse to communicate or interpret the medical jargon into lay terms for the men. The men were led to believe they were receiving the cure for "bad blood" they were actually suffering from syphilis. Ten years into the study, one-third of the time, the cure for syphilis, penicillin was discovered. The availability of the drug was withheld from the men in order to observe the effects the disease had on a human (Byman, 1991; Rosser, 1988). For most, that was death. The public health department used blacks' own cultural beliefs of "bad blood" against them in persuading them to participate in the program that the providers knew would kill the men. Even more over, there is little evidence if any that studies have been done on the women who were the partners to these 399 men. This reinforces mistrust of the system and further encourages isolation.

Disregard for Life's Experience

The fifth and final characteristic is a disregard of life's experience of racism. From the time of the arrival of slaves, the African American woman's role was to reproduce others that could be subjected to ethnic amplifiers. By making racism a part of the fabric woven into the health care system of America, the miserable life black women lived for hundreds of years could be justified. Unequal treatment, fear, domination are the epistemological foundation of health. Until

these issues are brought to the forefront they will continue to contribute to the disparities in health.

In order for the black woman to seek out treatment, a more ethnic sensitive biomedical model must be initiated. This model must take into consideration the dehumanization that took place over hundreds of years by the hegemonic issues of race. The traditional beliefs cannot be discredited or invalidated. They must be re-evaluated and dissected to allow women to retain appropriate culturally sensitive practices as a part of their health belief model. Barriers created by conventionally stripping black women of their role and status in certain institutional settings must be corrected. Black women are not women who want to suffer. They are women who have learned to survive after suffering. Now it is time to bring this full circle and promote the understanding that there is no need to suffer.

Educational programs must be placed in the medical schools addressing racial profiling. Racial profiling of different ethnic groups from a patient and providers perspective must be implemented. Racial profiling must be included in nursing schools. The warning signs of trauma must be included when addressing these issues. Factors that make up the identity of an individual that is isolated and persecuted should be discussed in medical arenas. As I stated in the beginning, I do not believe doctors intend to project discriminatory feelings upon their patients, however, certain attitudes and behaviors are adopted as a part of the cultural norms. Racism is a part of the Western culture. This is an area that must be addressed in the health care system.

Both patients and health care providers have their own cultural beliefs. Both have memorial experiences, some will be considered superior some will be inferior. Poor life experiences have to be acknowledged as a part of the racial and sexual hierarchy that prevents appropriate treatment outcomes. These are the experiences that are amplified. A new paradigm that includes bringing the racial profiles to the forefront as ethnic amplifiers to help identify the negative life experiences in order to convert them into positive life experiences they must be instituted into the medical schools. In the first semester students should have to take courses in understanding the history of "patients". They should become aware of how different groups were introduced to medicine. During some part of their board exams a portion on racial profiling should be tested. For drug representatives and pharmaceutical companies, better knowledge of experimentations must be recorded and used in training to avoid reoccurrence. Increased awareness of the poor quality of care, misuse of individuals and poor construction of black identity must take place in the medical system in order to improve the quality of care for all.

Conclusion

In summary, African American women view the entire landscape of racism in health care before they decide if they will become interdependent upon the system. The medical professionals values are a combination of those learned prior to medical school in addition to values taught in school. In the new millennium providers' values must go beyond life, death, birth, sexuality, sickness in the world of the physician, even surpassing pathophysiology and technique. They must delve into the lives of their patients for better understanding on how to

provide equal treatment. It is efficacious to understand the experience of medicine from the patient's perspective.

For the black woman values are a combination of what she learned, what she has experienced and what she knows about others experiences both black and white. Programs have not been developed in this culture that remove all suffering for African American women as yet. Thus her decision to participate in a program will only effect how she will suffer. Therefore, it must be communicated through society first that this is a culture that does not have to suffer in order to expect African American women to believe that. Breast cancer is becoming a public health problem. It is a disease that effects the general population because it affects the woman's family as well. It should be studied as though the general population was being treated poorly. In order to resolve the problem of black women presenting late the structural obstacles have to be removed. Then both the woman and the medical provider can benefit. In order to accomplish this, more research is needed and assistance provided in the medical schools with women as advocates. A beginning is focus groups using the five basic elements of the biomedical racial profile paradigm.

APPENDIX A
AFRICAN AMERICAN SUMMIT ON BREAST CANCER
PRE CONFERENCE SURVEY

Please complete the following by circling the first response that comes to mind and best fits **your** experience.

1. How do you feel about breast cancer among African American women?

Not at all worried worried to a degree worried quite a bit

2. When comparing breast cancer among African American women to women of other ethnic backgrounds do you consider breast cancer to be

No problem not as serious a problem a somewhat serious problem very serious problem

3. This summit is designed to provide me with new information about breast cancer and African American women.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

4. I expect to become a stronger breast cancer advocate in the community as a result of the information provided at this summit.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

5. The goal of this summit is to assist me in preparing programs that I can incorporate into my organization and deliver to the community.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

6. I am attending this summit to help me affirm some cultural beliefs, values and practices about breast cancer and how the disease affects African American women.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

7. I was selected to attend this conference because I am somewhat knowledgeable about underserved women and the issues of breast cancer among African American women.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

8. The purpose of this summit is to provide breast health education to those already working to strengthen and empower African American women in the state of Florida

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

The summit is organized by the American Cancer Society.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

9. The purpose of the summit is to help my organization develop a strategic plan that will increase understanding about breast health education among African American women.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

10. Overall, I think the summit is a good idea.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

Comments:

APPENDIX B
AFRICAN AMERICAN SUMMIT ON BREAST CANCER
POST-CONFERENCE SURVEY

Please complete the following by circling the response that best fits ***your*** experience.

11. How do you feel about breast cancer among African American women?

Not at all worried worried to a degree worried quite a bit

12. When comparing breast cancer among African American women to women of other ethnic backgrounds do you consider breast cancer to be

No problem not as serious a problem a somewhat serious problem very serious problem

13. This summit is designed to provide me with new information about breast cancer and African American women.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

14. The information provided in this conference will be useful to me in helping me become a better leader in the community.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

15. This summit will assist me in preparing programs that I can incorporate into my organization and deliver to the community.

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

16. This summit will help me affirm some of my cultural beliefs, values and practices about breast cancer and how it affects African American women .

Strongly Agree Agree Disagree Strongly Disagree Not Applicable

17. I was selected to attend this conference because I am already quite knowledgeable about breast cancer among African American women.

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

18. The purpose of this summit is provide additional information to those already working to strengthen and empower African American women in the state of Florida

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

19. Presenters will give participants information on how to access additional information about breast cancer.

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

20. The summit was organized by the American Cancer Society.

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

21. The summit will give me help my organization unite with other organizations to address breast cancer among African American women.

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

22. Overall I think the summit is a good idea.

Strongly Agree Agree Disagree Strongly Disagree Not
Applicable

Comments:

APPENDIX C
PRESENTING SITUATION
AND
INSTRUCTIONS TO THE STUDENT

DOTTY JOHNSON

Dotty Johnson is a 44-year-old African American female who is coming to you, a family physician in the clinic for her routine annual physical examination. She had blood work done a week ago so the results would be available for this visit. She did not have a mammogram this year because she had one last year that was normal. She has had regular mammograms done every other year since her late 30's. She is not aware of anyone in her family that had breast cancer.

She started menstruation at age 11. She has two children age 24 (Tina) and 19 (Chris) and has never been pregnant. Her only method of birth control used was birth control pills that she started using at age 18. She has been married for 25 years to Chris, her high school sweetheart.

MAMMOGRAM RESULTS:

Mammogram report indicates no evidence of malignancy in the left breast. In the right breast, there is a 1.1 cm speculated mass in the upper outer quadrant. This mass is strongly suspicious for malignancy.

You are to:

- Perform an appropriate confirmatory breast exam.
- Tell Mrs. Johnson the results of the mammogram.
- Discuss with her the next steps in dealing with this problem.

You have 15 minutes to perform these tasks. (A bell will ring 12 minutes into the encounter and again at the end of the encounter.)

You will then have 7 minutes to answer questions related to this case outside the patient room.

Video Script

DOTTY JOHNSON

PRESENTING COMPLAINT: Routine Breast Exam

ACTUAL DIAGNOSIS: Abnormal Mammogram/Giving Bad News

PATIENT NAME: Dotty Johnson

PATIENT DEMOGRAPHICS:

AGE: 39-45

SEX: Female

RACE: African American

HEIGHT: Average

WEIGHT: Slightly Overweight

CLINICAL CONSULTANT:

Frederick Grant, M.D.

PROFILE:

Dotty Johnson is the owner of a small janitorial company in the local area. She is coming to the doctor's office today for her annual check-up. She came in a week ago to have blood drawn done so that the results would be available for this appointment. She has no reason to suspect that anything is wrong or out of the ordinary. Therefore, she is shocked and devastated by the news that her mammogram came back showing a mass suspicious of cancer.

APPENDIX D
FOCUS GROUP QUESTIONS:

BREAST CANCER SURVIVORS

1. Where do you go to get updated ethnic sensitive health information ? How often? For what problems specifically.
2. How often do you watch TV? Which stations, TV ? Which shows do you find credible?
3. Do you read magazines? Why/why not?
Which ones do you read? How often?
Do you subscribe? If not, where do you read magazines?
Do you use magazines as a source of information about your patients ?
How credible are magazines as a source of health information ?
Do you believe the information that you read about the health information?
4. How often do you listen to the radio?
Which stations? How often?
Do you think that the radio is a good source of health information?
Why/why not?
5. Do you read the newspaper(s)? How often?
Which newspaper(s) do you read?
Which sections do you read most often? Least often?
Do you think newspapers are good sources of health information? Why/why not?
Do you believe the stories that you read in the newspapers?
6. Do you have access to the Internet?
7. What do you think is the most pressing issue among African American women about breast health education?
8. How do you view the issues of early detection and screening for breast cancer?
9. What problems do you think African American women have with early detection and screening?
10. What do you think would better help African American women to become informed about breast health education?

11. What kinds of services would you like to have available to help providers communicate with African American women about breast cancer?
12. What would be your idea of the best way to communicate with African American women about breast health education?
13. What kinds of staff do you think providers would need to talk to African American about breast health education?
14. What other types of support systems would you like to see in place to assist African American women with breast health education?
15. What are some of the topics that you would like to see specifically addressed about African American women and breast cancer?
16. What do you think deters African American women from seeking early treatment?
17. How do you think communication between doctor and patient can be improved?
18. What are your specific suggestions for improvement.

LIST OF REFERENCES

- Adams, M.L., H.Becker and A.Colbert
2001 'African American Women's Perceptions of Mammography Screening. *Journal of Black Nurses Association*.12(2):44-8.
- Aldridge, Delores P.
1993 *Focusing: Black Male-Female Relationships*. Chicago. Third World Press.
- Allport Gordon W.
1979 *The Nature of Prejudice*. Reading: Perseus Books.
- Altpeter, Mary Jo Ann, L. Earp, and Ajnice Schopler.
1998 Promoting Breast Cancer Screening In Rural African American Communities: The Science and Art of Community Health Promotion (Special Issue on Cultural and Ethnic Diversity). *Health and Social Work* 23:2:104.
- American Cancer Society..
2001 *Cancer Facts & Figures 2001*. Atlanta, Georgia
- American Cancer Society.
2000 *Cancer Facts and Figures*. Atlanta, Georgia.
- Ashing-Girwa, Kimlin.
1999 The Recruitment of Breast Cancer Survivors Into Cancer Control Studies: Focus on African-American Women. *Journal of The National Medical Association* 91:5:255-260.
- Baer, Hans A.
1997 The Misconstruction of Critical Medical Anthropology: A Response to a Cultural Constructivist Critique. *Social Science Medicine*. Vol 44(10):1565-1573.
- Baer, Hans A., Merrill Singer and Ida Susser
1997 *Medical Anthropolpogy and the World System: A Critical Perspective*. Wesport, Conn: Greenwood Publishing Company.

- Baer, Hans A and Yvonne Jones (eds).
 1992 African Americans in the South, Issues of Race, Class and Gender. Southern Anthropological Proceedings, No 25 .Athens: University of Georgia Press
- Bailey, Eric.
 2000 Medical Anthropology and African American Health. Westport, CT.:Bergin & Garvey.
- Bailey, Eric, Deborah O. Erwin and Precilla Belin.
 2001 Using Cultural Beliefs and Patterns to Improve Mammography Utilization Among African-American Women. The Witness Project®. Journal of National Medical Association. 92:136-142.
- Baker, Lee D
 1998 From Savage to Negro. Anthropology and the Construction of Race, 1896-1954. Berkeley: University of California Press.
- Banta, David H., and Renee C. Fox.
 1972 Social Science and Medicine. 6(6):697-722.
- Barbee, Evelyn.
 1994 Racism in U.S. Nursing. Medical Anthropology Quarterly 7(4):346-362.
- Barnard, Alan
 2000 History and Theory in Anthropology. Massachusetts:Cambridge University Press.
- Barrett Bruce.
 1997 Identity, Ideology and Inequality:Methodologies in Medical Anthropology, Guatemala 1950-1995. Social Science and Medicine 44:5:579-588.
- Barth, Frederick.
 1969 Ethnic Groups and Boundaries: The Social Organization of Culture. Differences. (F Barth, ed)London:George Allen and Unwin.
- Bernard, H. Russell.
 1995 Research Methods In Anthropology, Qualitative and Quantitative Approaches. Walnut Creek.:Calif. Sage
- Bennett,Jr., Lerone
 1975 The Shaping of Black America. New York: Penguin Books

Bettters-Reed, B.L. and L.L. Moore.

- 1995 Shifting the Management Development Paradigm for Women.
Journal of Management Development 14:24-38.

Belgrave, Linda Liska and Julia Bradshear..

- 1994 Health as a Factor in Institutionalization, Disparities Between
African Americans and Whites. Research on Aging. 16:(2) 115-
141.

Bibb, S.C.

- 1993 Access and Late-Stage Diagnosis of Breast Cancer in the Military
Health, Military Medicine 165(8): 585-590.

Bilimonia, Malcolm M., and Monica Morrow.

- 1994 The Woman at Increased Risk for Breast Cancer: Evaluation and
Management Strategies. A Cancer Journal for Clinicians 45:5:263-
278.

Bione, Victoria Jackson

- 1990 Psychological Androgyny: A Black Female Perspective. Sex Roles,
22,(7/8):487-507

Blake, J. Herman.

- 1984 Doctor Can't Do Me No Good: Social Concomitants of Health Care
Attitudes and Practices Among Elderly Blacks in Isolated Rural
Populations. In Black Folk Medicine, (Wilbur H Watson, ed) New
Brunswick, New Jersey: Transaction Books.

Blassingame, John W.

- 1979 The Slave Community Plantation Life in the Antebellum South. New
York, New York: Oxford University Press.

Boas, Franz.

- 1936 History and Science in Anthropology: A Reply, American
Anthropologist 38:137-51.

Bonvillain, Nancy.

- 1993 Language, Culture and Communication. Englewood.Cliff :N.J.
Prentice Hall.

Bourjolly, Joretha N., Toba Schwaber Kerson, and Isaac F. Nuamah

- 1999 A Comparison of Social Functioning Among Black and White
Women With Breast Cancer. Social Work in Health Care 28:(3):1-
21.

Bradley Leon, Michael P. Osborne and Umberto Veronesi.

- 1994 Breast Cancer in African American Families: Risk Perception, Cancer Worry and Screening, Practices of First-Degree Relatives. *Annals of the New York Academy of Sciences*, 768:281-285.

Branch William, Richard J. Pels, Robert S. Lawrence & Ronald Arky.

- 1997 Becoming a Doctor: Critical-Incident Reports From Third-Year Medical Students. In *The Social Medical Readers*. (Gail E. Henderson, Nancy M. P. King, Ronald P. Strauss, Sue E. Estroff, Larry R. Churchill eds). Durham, N.C.: Duke University Press. P223-227.

Brewster, Abenaa.

- 1997 A Student's View of a Medical Teaching Exercise. In *The Social Medical Reader*. (Gail E. Henderson, Nancy M.P. King, Ronald P. Strauss, Sue E. Estroff, Larry R. Churchill eds). Durham: Duke University Press.

Brown, Peter J. (ed).

- 1988 *Critical Medical Anthropology, Understanding and Applying Medical Anthropology*. Mountainview: Calif. Mayfield Publishing Company.

Brown, Peter J., Jessica Gregg and Bruce Ballard.

- 1997 Culture, Evolution and the Practice of Medicine, Human Behavior for Medical Students, (Alan Stoudemire, ed). New York: New York, Lippincott.

Brown, Peter J.

- 1996 Anthropology and Studies of Human Reproduction. In *Medical Anthropology: Contemporary Theory and Method* (Carolyn Sergeant and Thomas Johnson, eds.) Westport, Ct: Preager, pp 219-234.

Brown, Peter J., Marcia Inborn and Daniel Smith

- 1995 Disease, Ecology and Human Behavior. In *Medical Anthropology Contemporary Theory and Method*, (Carolyn Sergeant & Thomas Johnson, eds), Westport , Ct: Preager, pp 89-109.

Burnett, Caroline B. Caryn S. Steakley, and Mariella C. Tefft.

- 1995 Barriers to Breast and Cervical Cancer Screening in Underserved Women of the District of Columbia. *Oncology for Nursing* 22:(10):1551-1555.

- Buka, S.L.
2002 Disparities in Health Status and Substance Use: Ethnicity and Socioeconomic Factors. Public Health Reports, 117(1):S118-125.
- Byman, Beryl.
1991 Out from the Shadow of Tuskegee Fighting Racism in Medicine. Minnesota Medicine 74:15-20.
- Byrd Michael and Linda A Clayton.
2002 In Unequal Treatment: Confronting Racial and Ethnic Disparities in Health. (Brian D. Smedley, Adrienne Y Stith and Alan R. Nelson eds). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, D.C. National Academies Press.
- 2000 American Health Dilemma: A Medical History of African Americans and the Problem of Race: Beginnings to 1900. Volume One. New York: Routledge.
- Campbell, JB
2002 Breast Cancer-Race, Ethnicity and Survival: A Literature Review. Breast Cancer Research and Treatment. 74:2:187-192.
- Canto, Maria Teresa, William F. Anderson and Otis Brawley
2001 Geographic Variation in Breast Cancer Mortality for White and Black Women: 1986-1995. CA Cancer Journal 51:367-370.
- Carlisle, David M., Barbara D. Leake, Martin F. Shapiro
1997 Racial and Ethnic Disparities in the Use of Cardiovascular Procedures Associated with Type of Health Insurance. American Journal of Public Health 87:(2):263-266.
- Chang, Sophia W., Karla Kerlikowski, Anna Napoles-Springer, Samuel F. Posner and Edward Sickles.
1996 Racial Differences in Timeliness of Follow-Up After Abnormal Screening Mammography. American Cancer Society 78:(7):1395-1402.
- Chavez, Leo R. Juliet M. McMullin, Shiraz I Mishra and F. Allan Hubbell.
2001 Beliefs Matter: Cultural Beliefs and the Use of Cervical Cancer-Screening Tests. American Anthropologists 103:4:1114-1129.
- Chavez, Leo R., Allan F. Hubbell, Juliet M. McMullen, Rebecca G. Martinez and Shiraz I. Mishra.
1995 Understanding Knowledge and Attitudes About Breast Cancer. Archives of Family Medicine 4:145-152.

- Chen, F., E.J. Trapido and K. Davis
 1994 Differences in Stage at Presentation of Breast and Gynecological Cancers Among Whites, Blacks and Hispanics. *Cancer* 1:(73):11:2838-2842.
- Chevarley Frances and White Emily
 1997 Recent Trends in Breast Cancer Mortality Among White and Black Women in the United States. *American Journal of Public Health* 87(7):75-781.
- Clasen, Carla M.
 1994 A Survey of Physician Beliefs and Self-Reported Practices Concerning Screening for Early Detection of Cancer, *Social Science & Medicine*, 39:3, pp343-368.
- Coday M, LK Klesges, RJ Garrison, KC Johnson, M O'Toole and GS Morris
 2002 Health Opportunities with Physical Exercise (HOPE):Social Contextual Interventions to Reduce Sedentary Behavior in Urban Settings. *Health Education Research*.17(5):637-647.
- Collins, Patricia Hill.
 1997 *Fighting Words, Black Women and the Search for Justice*. Minneapolis, Minnesota: University of Minnesota Press.
- Copeland, Valerie Carr, and Sara Hudson Schoelle.
 2000 Patient Satisfaction and African American Women :A Missing Link in Health Services Research. *African American Research Perspectives* (6):2:48-56.
- Cozier, Y, J.R. Palmer, L. Rosenberg, L.L. Adams-Campbell.
 2001 Recent Mammography Use Among African American Women. *Ethnicity and Disease*.11(2):188-91.
- Crump, S.R., R.M. Mayberry, B.D. Taylor, K.P. Barefield, and P.E. Thomas.
 2000 Factors Related to Noncompliance with Screening Mammogram Appointments Among Low-Income African-American Women. *Journal National Medical Association* 5:237-246.
- Cummings, Carol M, Adrienne M Robinson and Fretchen E. Lopez
 1993 Perceptions of Discrimination, Psycho-social 'Functioning and Physical Symptoms of African-American Women.(Barbara Bair and Susan E. Cayleff eds) *Wings of Gauze: Women of Color and the Experience of Health and Illness*. Detroit. Wayne State University,pp. 53-67.

- Cummings, K.M., A. Michalek, and D.I. Gregorio.
 1983 Delay, Stage of Disease, and Survival Among White and Black Women with Breast Cancer. *American Journal of Public Health* 73(5):590-593.
- Danigelis, Nicholas L., Norma L. Roberson, John K. Worden, Brian S. Flynn
 1996 Breast Cancer Screening in African-American Women. Insights from a Household Survey and Focus Group. *American Journal Preventive Medicine* 11(5):311-317.
- Davis, Angela Y.
 1981 *Women Race and Class*. New York: Vintage Books.
- Davis, Terry C., Connie Arnold, Hans J. Berkel, Indrani Nandy, Robert H. Jackson and Jonathan Glass.
 1996 Knowledge and Attitude on Screening Mammography Among Low-Literacy, Low-Income Women. Atlanta:GA. American Cancer Society.
- Dennis, G.C.
 1999 Racism in Medicine. *Journal of National Association of Medicine*. 91(5):251-2.
- Derbyshire, John.
 2001 In Defense of Racial Profiling: Where Is Our Common Sense. National Review Inc.
 53:3:www.nationalreview.com/Derbyshire/Derbyshire-archive.asp.
- Devore, Wynetta, and Elfriedge G. Schlesinger.
 1991 *Ethnic-Sensitive Social Work Practice* (3rd ed) New York. Macmillan Publishing Company.
- Dignan, M., R. Michielutte, P. Sharp, J. Bahnson, L. Young and P. Beal.
 1990 The Role of Focus Groups in Health Education for Cervical Cancer Among Minority Women. *Journal of Community Health* 15(6):369-375.
- Dignan, M., R. Michielutte, P. Sharp, L. Young and L.A. Daniels
 1991 Use of Process Evaluation to Guide Health Education in Forsyth County's Project to Prevent Cervical Cancer. *Public Health Reports* 106(1):73-77.

- Douglass, Merrian, Alfred Bartolucci, John Waterbor and Ann Sirls.
 1995 Breast Cancer Early Detection: Differences Between African American and White Women's Health Beliefs and Detection Practices. *Oncology Nursing Forum* 22:(5):835-837.
- Dovidio, J.F., S.L. Gaertner, and A. Validzic.
 1998 Intergroup Bias: Status, Differentiation and a Common In-Group Identity. *Journal of Personality and Social Psychology*. 75(1)109-120.
- Drake, St. Clair.
 1990 *Black Folk Here and There*. Los Angeles: Center for Afro-American Studies.
- Dressler, William W.
 2000 The Health Consequences of Cultural Consonance: Cultural Dimensions of Lifestyle. Social Support and Arterial Blood Pressure in an African American Community. *American Anthropologists* 102:244-260.
 1995 Social Status and the Health of Families: A Model. *Social Science Medicine*, 39:(12)1605-1613.
 1993 Social and Cultural Dimensions of Hypertension in Mechanism (In) Pathophysiology of Hypertension in Blacks (John C.S. Fray and Janice G. Douglas, eds.) New York: Oxford: University Press, 69-89.
- Dressler, William W and James R. Bindon.
 2000 The Health Consequences of Cultural Consonance: Cultural Dimensions of Lifestyle, Social Support, and Arterial Blood Pressure. *American Anthropologists*. 102:2:244-260.
- Dubois, W.E.B.
 1985 *Against Racism: Unpublished Essays, Papers, Addresses, 1887-1961* Herbert Apatheker, eds. Amhersts: University of Massachusetts.
- DuBois, W.E.B.
 1962 *Black Reconstruction in America*. New York. Touchstone
 1902 *Souls of Black Folk*, Chicago. Lushena, Books, Inc.

- Dubos, Rene.
1993 *The Mirage of Health*. New Brunswick:Rutgers University Press.
- Dull, Valerie T.
1995 A Cognitive Model of Religion's Influence on Health (Special Issue: Religious Influences on Personal and Societal Well-Being) *Journal of Social Issues*:51:2:49-65.
- Dunnavant, Sylvia
1994 *Celebrating Life: African American Women Speak Out About Breast Cancer*. (Sharon Egiebor, ed). Dallas Texas.
- Dye, Nancy S., and Mary Breckinridge.
1984 *The Frontier Nursing Service and the Introduction of Nurse-Midwifery in the United States*. In *Women and Health in America* (Judith Walzer Leavitt,ed. Madison: University of Wisconsin Press.
- Ekah, Akpofure P., Rebecca S. Alleyne and Albert O. Duncan
2002 Role of Mammography in Diagnosis of Breast Cancer in an Inner City Hospital. *Journal of the National Medical Association* 92:(8):372-374.
- Eley, JW., H.A. Hill, and VW. Chen, D.F. Austin, MN. Wesley, HB Muss, RS Greenberg, R.J. Coates, P. Correa, et al.
1994 Racial Differences in Survival from Breast Cancer Results of the National Cancer Institute Black/White Cancer Survival Study. *JAMA* 272(12):947-954.
- Eng, Eugenia
1993 *The Save Our Sisters Project*. *Cancer Supplement*. 72:(3):1071-1077.
- Engelhardt, H Tristram
1996 *Suffering, Meaning and Bioethics*. *ChristiaBioethics*. 2(2):129-153.
- Epperson, Thomas W.
1994 *The Politics of Empiricism and the Construction of Race as an Analytical Category*. *Transforming Anthropology* 5(1&2):15-20.
- Erwin, Deborah, O., Thea S. Spatz, TC Stotts and J.A. Hollenberg
1999 Increasing Mammography Practice by African American Women. *Cancer Practice* 7:(1):81-93.

Erwin, Deborah, L. Deloney, H. Dai, L. Erkman

- 1995 The Role of the Cancer Registry in Building Outreach Programs: The Witness Project® example. *Journal of Registry Management* 23:79-85.

Erwin, Deborah O., Thea S. Spatz, Ches R. Craig Stotts, Jan A Hollenberg, Linda A. Deloney.

- 1995 Increasing Mammography and Breast Self-Examination in African American Women Using the Witness Project® Model. *Journal of Cancer Education* 11:4:210-215.

Fabrega, Horacio.

- 1993 Biomedical Psychiatry as an Object for a Critical Medical Anthropology. In *Knowledge, Power & Practice: The Anthropology of Medicine and Everyday Life*. (Shirley Lindenbaum and Margaret Lock, eds). Berkeley. University of California Press. 166-188.

Farrell Charles S..

- 1996 Is Racism a Male Thing? Study Suggests That Men Have Less Tolerance Than Women. *Black Issues in Higher Education*. 13:(6):22-25.

Farrow, Diana C., William C. Hunt and Jonathan Samet.

- 1992 Geographic Variation in the Treatment of Localized Breast Cancer. *The New England Journal of Medicine* 326:(17):1097-1101

Feagin, Joe R.

- 2000 *Roots, Current Realities and Future Reparations*. New York: Routledge

Feagin, Joe R., and Melvin P. Sikes.

- 1994 *Living with Racism, the Black Middle-Class Experience*. Boston: Beacon Press.

Fife, Betsy.

- 1995 The Measurement of Meaning in Illness. *Social Science Medicine* 40(8):1021-1028.

Fishel, Elizabeth.

- 2000 *Reunion the Girls We Used to Be, The Women We Became*. 1st Edition. New York: Random House.

Flaws, JA., CJ. Newschaffer and TL. Bush

- 1998 Breast Cancer Mortality in Black and in White Women: A Historical Perspective By Menopausal Status. *Journal of Women's Health* 7:(8):1007-1015.

- Folbre , Nancy
1993 Women's Work in the World Economy. New York:New York University Press.
- Ford, Angela.
1999 Older Black Women, Health and the Black Helping Experience. African American Researcher Perspectives 5:(1):1-10.
- Foster Jr., Henry W.
1996 Women's Health Care for the Coming Millennium. The Journal of the Florida Medical Association 84(6):358-363.
- Fox-Genovese, Elizabeth.
1988 Within The Plantation Household, Black and White Women of The Old South.Chapel Hill. University of North Carolina Press.
- Foucault, Michel
2000 Power. James D. Faubion (ed).New York:New Press.
- Frankenberg, Ruth.
1995 White Women, Race Matters, The Social Construction of Whiteness. Minneapolis: University of Minnesota Press.
- Frank-Stromberg, M. Johnson, and R. McCorkle.
1987 A Program Model for Nurses Involved with Cancer Education of Black Americans. Journal of Cancer Education 2:(3):145-151.
- Frelix, Gloria D.,Ruth Rosenblatt, Mary Solomon, and Bhadrasain Vikram.
1999 Breast Cancer Screening in Underserved Women in the Bronx. Journal of the National Medical Association 91:(4):195-200.
- Freud, Sigmund.
1995 The Ego and The Id. New York: Norton.
- Friere AX., GE. Umpierrez, B.Afessa, K.A.Latif, L.Bridges and A.E. Kitabechi.
2003 Predictors of Intensive Care Unit and Hospital Length of Stay in Diabetic Ketoacidosis,. Journal of Critical Care. 17(4):207-211.
- Fuller, Suzanne, Robert McDermott, Richard G..Roetzheim and Philip J. Marty.
1992 Breast Cancer Beliefs On Women Participating in a Television-Promoted Mammography Screening Project. Washington,D.C.:U.S. Department of Health, Public Health Reports.

- Gary, Faye, Campbell and Carla Serlinq.
1996 African American Women Disparities in Health Care. *Journal of the Florida Medical Association*. 83:(7):489-497.
- Gates Jr., Henry Louis
1986 *Race, Writing and Difference*, Chicago:University of Chicago.
- Geertz, Clifford.
1983 *Local Knowledge* (3rd ed) New York:Basic Books, Inc.
- Geiger, H. Jack,
2002 Racial and Ethnic Disparities in Diagnosis and Treatment A Review of Evidence and Consideration of Causes. (In) *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine of the National Academies. Washington, D.C.:The National Academies Press. Pp 415-454
- Gibbs, Tyson.
1997 Afrocentrism in the 21st Century, *The Western Journal of Black Studies*, 21:(3):173-179.
- Gibbs Tyson, Kathleen Cargill, Leslie Sue Lieberman and Elizabeth Reitz.
1980 *Cross-cultural Studies in Health and Illness*. *Medical Anthropology*. 42:171-262.
- Giddings, Paula.
1993 *When and Where I Enter: The Impact of Black Women on Race and Sex in America*. New York, William Morrow.
- Giger, JN.
2001 Ending Health Disparities in African American Men: A Clarion Call to Arms. *Journal of Black Nurses Association*. 12::vii-viii.
- Good, Byron J., and Mary-Jo Good.
1993 Learning Medicine: The Constructing of Medical Knowledge at Harvard Medical School. In *Knowledge, Power and Practice. The Anthropology of Medicine and Everyday Life* Shirley Lindenbaum & Margaret Lock (editors). Berkeley. University of California Press pp.81-107.
- Gorey, K.M., and J.E. Vera.
1995 The Association of Near Poverty Status With Cancer Incidence Among Black and White Adults. *Journal of Community Health* 20:4:359-366.

- Guidry, Jeffrey J., Patricia Matthews-Juarez and Valerie A. Copeland
 2003 Barriers to Breast Cancer Control for African-American Women. The Interdependence of Culture and Psychosocial Issues. *Cancer* 97(S1):318-323.
- Green, Linda
 1998 Lived Lives and Suffering: Problems and Concerns in Medical Anthropology. *Medical Anthropology Quarterly*, 12:1:3-7.
- Green-Powell, Patricia
 1997 Methodological Considerations in Field Research: Six Case Studies Oral Narrative Research With Black Women (editors). Thousand Oaks. Sage.
- Greenberg, M. and D. Schneider.
 1995 The Cancer Burden of Southern-Born African Americans: Analysis of Social-Geographic Legacy. *The Milbank Quarterly*, 73:4:599-618.
- Guidry, JJ., P. Matthews-Juarez and VA Copeland
 2003 Barriers to Breast Cancer Control for African American Women; the Interdependence of Culture and Psychosocial Issues. *Cancer* 97:1Suppl:318-323.
- Hacker, Andrew.
 1992 Two Nations: Black and White, Separate, Hostile, Unequal. New York:Ballantine Books.
- Hahn, Robert.
 1995 *Sickness and Healing: An Anthropological Perspective*. New Haven: Yale University Press.
- Hahn, Robert A., Elaine Eaker, Nancy D. Baker, Steven M. Teutsch, Waldemar Sosniak and Nancy Krieger.
 1995 Poverty and Death in the United States-1973 and 1999. *Epidemiology* 6:490-497.
- Haraway, Donna.
 1993 The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse. *The Anthropology of Medicine and Everyday Life*. Shirley Lindenbaum and Margaret Lock. Berkeley: University of California Press, pp. 364-410.
- Harding, Sandra.
 1989 Is There a Feminist Method. *Feminism and Science*. Nancy Tuana (ed.) Bloomington. Indiana University Press, pp. 17-32.

Harris, Marvin.

1989 *Our Kind*. New York:Harper.

Harrison, Ira.

1972 Patients Evaluation of Neighborhood Health Centers. *Journal of National Medical Association* 64:(4):348-353.

1979 *Traditional Healers: A Neglected Source of Health Manpower*:Waltham:Crossroads Press. 197-201.

1978 The Agricultural Migratory Farm Labor System As An Adaptive Mechanism For Afro-Americans. *Tennessee Anthropologists* 3:2:168-186

Harrison III, Robert W.

2001 Impact of Biomedical Research on African Americans *Journal of the National Medical Association* 93:(3)(supp)65-75

Heidenreich, PA., MG Shlipak MG., Geppert J., and M.MCClellan

2002 Racial and Sex Differences in Refusal of Coronary Angiography. *American Journal Medicine*. 113:3:200-207

Hildredth, Gladys J., Major L. Boglin, and Keith Mask.

1999 Review of Literature on Resiliency in Black Families: Implications or the 21st Century. *African American Research* 6:(1):13-22.

Hill, Carole E.

1976 A Folk Medical Belief System in the American South: Some Practical Considerations. *Southern Medicine*, 64(6)11-17.

Hines, Darlene Clark and Kathleen Thompson.

1998 *A Shining Thread of Hope:The History of Black Women in America*. New York, New York:Broadway Books.

Hooks, Bell.

1981 *Ain't I A Woman:Black Women and Feminism*.Boston:South Bend Press.

1990 *Yearning:Race, Gender and Cultural Politics*. Boston:South End Press.

1995 *Culture to Culture: Ethnography and Cultural Studies as Critical Intervention in Yearning, Race Gender and Cultural Politics*,Boston: South End Press.

- 1996 Black Women: Shaping Feminist Theory. In *Words of Fire: An Anthology of African American Feminist Thought* (Beverly Guy-Sheftall, ed). New York, The New Press.
- Hughes-Gaston, Marilyn and Gayle K. Porter.
 2001 *Prime Time: The African American Women's Complete Guide to Midlife Health and Wellness*. New York: Ballantine Publishing Company.
- Hyman, DJ, and VN Pavlik.
 2002 Poor Hypertension Control: Let's Stop Blaming the Patients. *Cleveland Clinic Journal of Medicine*. 69(10):793-799.
- Hyman, Ruth Bernstein and Stephen Baker.
 1992 Construction of the Hyman-Baker Mammography Questionnaire: A Measure of Health Belief Model Variables. *Psychological Reports*. 71, 1203-1215.
- Inhorn, Marcia C.
 1995 Medical Anthropology and Epidemiology: Divergences Or Convergences? *Social Science Medicine* 40:3:285-290.
- Izquierdo-Porrera, AM., CC Powell, J Reiner, KR Fontaine.
 2002 Correlates of Exercise Adherence in an African American Church Community. *Cultural Diversity Ethnic Minority Psychology*. 8:4:389-394.
- Jackson, Karen.
 1997 Black Women With Cancer Find Support in Their Own Group. *New York Times*. October 19, 1997. Sec1: pp27:1.
- Janz, NK., and Becker, MH.
 1984 The Health Belief Model: A Decade Later. *Health Education Quarterly* 11: 1-47.
- Jeffers, Sheila B.
 1998 Ethnic Amplifiers in Breast Cancer. Second Meeting of National Meeting of Women's Health, Multidisciplinary Models for Excellence, (Leslie Sue Lieberman, Virginia M. Steitz, Leilani Doty, Sue Rosser and Miriam S. Zach eds.). University of Florida Center for Research on Women's Health and Institute on Aging, pp 102-109.

- 2002 A Community Response to Preventive Breast Health Care For African American Women. In *Successful Aging: Women's Health and Well-Being in the Second 50 Years*. (Leilani Doty, Leslie Sue Lieberman, Marcha Flint, Kathryn Grant eds.) University of Florida Health Science Center, Center for Research on Women's Health and Institute on Aging, pp. 38-46.
- Jennings, Kathleen.
- 1997 Getting Black Women to Screen for Cancer: Incorporating Health Beliefs into Practice. *Journal of the American Academy of Nurse Practitioners* 8:(2):53-59.
- Joe, Jennie R., Jacquetta Swift and Robert S. Young.
- 2002 The Rationing of Healthcare and Health Disparity For American Indians and Alaska Natives. (In) *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press. pp.528-551.
- Johnson CC., MJ. Worsham, J. Abrams, A. Blount, U. Raju, SR. Wohman and D. Nathanson.
- 1996 Ethnic Differences in Survival Among Women in Breast Cancer in a Health Care System (meeting abstract). *Proceedings from Annual Meeting of American Cancer Research: Poster Session*, 37:A1727.
- Keller, Evelyn Fox.
- 1985 Feminism and Science. *Signs. Journal of Women in Culture and Society* 7:(3):1982. 589-602.
- Keller, Evelyn Fox ,and Helen E. Longino.
- 1996 *Feminism and Science*. Oxford. Oxford: University Press.
- Krober, Alfred L., and Clyde Kulckhohn..
- 1952 Culture, A Critical Review of Concepts and Definitions.. *Papers of The Peabody Museum of American Archaeology and Ethnology*, vol.47. Cambridge Harvard University Press.
- Kubik. K
- 1999 A Suffering Person's Right in the Light of John Paul II Teaching. *Przegląd Lekarski*. 56:3:253-260.
- Laitin, David.
- 1986 *Hegemony and Culture: Politics and Religious Change Among Yoruba* Chicago: University of Chicago Press.

- Lannin Donald R., Holly F. Matthews, Jim Mitchell, Melvin S Swanson, Frances H. Swanson, and Maxine S. Edwards.
 1998 Influence of Socioeconomic and Cultural Factors on Racial Differences in Late-Stage Presentation of Breast Cancer. *Journal of American Medical Association* 279:(22):1801-1807
- Lannin, Donald R., Holly F. Mathews, Jim Mitchell and Melvein S. Swanson.
 2002 Impacting Cultural Attitudes in African American Women to Decrease Breast Cancer Mortality. *The American Journal of Surgery*. 184(5)418-423.
- Lawson EJ.
 1998 A Narrative Analysis:A Black Woman's Perceptions of Breast Cancer Risks and Early Detection. *Cancer Nurse*. 6:421-429.
- LeClere, Felicia, Jensen Leif, and Ann E. Biddlecom.
 1994 Health Care Utilization, Family Context, and Adaptation Among Immigrants to the United State. *Journal of Health and Social Behavior*, 35:(4):370-384.
- Leggat JE Jr, RD Swartz and FK Port.
 1997 Withdrawal From Dialysis: A Review With An Emphasis on the Black Experience.*Advanced Renal Replacement Therapy*. 4:11:22-29.
- Levine, RS., JE Foster, RE Fullilove, MT Fullilove, NC Briggs, PC Hull, BA Husaini, CH Heunekens.
 2001 Black-White Inequalities in Mortality and Life Expectancy, 1933-1999:Implicaitons For Healthy People 2010. *Public Health Report*. 116:5:474-483.
- Lieberman, Leslie S., Eleanor P. Stoller and Mary Ann Burg.
 1998 Women's Health Care:Cross-Cultural Encounters Within the Medical System. *Journal of the Florida Medical Association*.
- Link Bruce G., Frances Palamara Mesagno, Maxine E. Lubner and Bruce P. Dohrenwend.
 1990 Problems in Measuring Role Strains and Social Functioning in Relation to Psychological Symptoms. *Journal of Health and Social Behavior* 31:354-369.
- Loehrer, Patrick J., Heidi A. Greger, Morris Weinberger, Beverly Musick, Michael Miller, Craig B. Nichols, John Bryan, Debra Higgs, and Debra Brock.
 1991 Knowledge and Beliefs About Cancer in a Socioeconomically Disadvantaged Population. *Cancer* 7:1665-1671.

Lock, Margaret and Nancy Scheper-Hughes.

- 1996 *A Critical-Interpretive Approach In Medical Anthropology Rituals and Routines of Discipline and Dissent, Medical Anthropology Contemporary Theory and Method*, (Carolyn Sergeant and Thomas, eds), Boulder: Westview, pp 41-70.

Long, Earnesteen.

- 1992 *Breast Cancer in African-American Women*. *Cancer Nursing* 16:(1):1-24.

Longress, John F.

- 1999 *Human Behavior in the Social Environment*. Itasca: P.E. Peacock Publishers, Inc.

Lourde, Audre.

- 1984 *Sister/ Outsider: Essays and Speeches*. New York: Crossing Press.

Manderson, Lenore.

- 1999 *Gender Normality and Post Surgical Body*. *Anthropology and Medicine* 6:(3):381-395.

Mann, Coramae Richey.

- 1993 *Unequal Justice: A Question of Color* Bloomington; Indiana University Press

Marshall, Nancy L., and Rosalind Barnett.

- 1991 *Race, Class and Multiple Role Strains and Gains Among Women Employed in the Service Sector*. *Women and Health*, 17:(4):1-9.

Mathews Holly.

- 2000 *Negotiating Cultural Consensus in a Breast Cancer Self-Help Group*. *Medical Anthropology Quarterly* 14(3):394-413.
- 1998 *Methodological Approaches to the Study of Reasoning*. *Medical Anthropology Quarterly*. 12(3):358-362.

Mathews, Holly F., Donald R. Lannin, and James P. Mitchell.

- 1994 *Coming to Terms With Advanced Breast Cancer: Black Women's Narratives from Eastern North Carolina*. *Social Science Medicine* 38(6):739-800.

Mattis, Jacqueline.

- 1997 *Spirituality and Religiosity in the Lives of Black Women* *African American Research Perspectives* 3:(2):56-60.

- Mayberry, Robert M. RJ Coates, HA Hill, LA Click, VW Chin, DF Austin,CK Redmond, CM Fenoglio-Preiser, CP Hunter,CP Haynes,
1995 Determinants of Black/White Differences in Colon Cancer Survival. *Journal of National Cancer Institute*, Vol., 87:22:1686-1693.
- Meillassoux, Claude.
1997 *The Slave Trade and Development :The Routers and the Traces of Slaves*. Diogenes 179:23-30.
- Messing, Karen
1983 *The Scientific Mystique :Can a White Lab Coat Guarantee Purity in the Search for Knowledge About the Nature of Women? In Women's Nature:Rationalizations of InEquality*. Marian Lowe and Ruth Hubbard (ed).New York:Pergamon Press.
- McClaurin, Irma.
2001 *Introduction: Forging a Theory, Politics, Praxis, and Poetics of Black Feminist Anthropology*. In *Black Feminist Anthropology: Theory, Politics, Praxis and Poetics*.(Irma McClaurin ed.) New Jersey: Rutgers University Press.
- McCullough, L.B.
1983 *Bioethics*. *New Physician*. 9:31.
- McDonald, PA., DD Thorne, JC Pearson, LL Adams-Campbell.
1999 *Perceptions and Knowledge of Breast Cancer Among African American Women Residing in Public Housing*. *Ethnic Disparities*.9:1:81-93.
- McElroy, Ann and Patricia K. Townsend.
1996 *Medical Anthropology in Ecological Perspective*. Boulder,;Westview Press.
- McEwan Siobhan L, Anton F.deMan and Paul Simpson-Housley.
2002 *Ego-Identity Achievement and Perception of Risk in Intimacy in Survivors of Stranger and Acquaintance Rape*.*Sex Roles*.281:7.
- McMullin, Juliet M., Leo Chavez, & F. Allan Hubbell.
1996 *Knowledge, Power and Experience: Variation in Physicians' Perceptions of Breast Cancer Risk Factors*. *Medical Anthropology* 16:295-317.
- Messing, Karen.
1998 *Hospital Trash Cleaners Speak of Their Role in Disease Prevention*. *Medical Anthropology Quarter*. 12:(2):126-187.

- Mickey, Ruth, John Durski, John K. Worden and Nicholas Danigelis.
1996 Breast Cancer Screening and Associated Factors for Low-Income African American Women. *Preventive Medicine* 24:467-476.
- Michalski, Tracy A. and Ann B. Nattinger.
1997 The Influence of Black Race and Socioeconomic Status on the Use of Breast-Conserving Surgery for Medicare Beneficiaries. *The American Cancer Society* 79:(2):314-319.
- Minino AM, E Arias, KD Kochanek, SL Murphy and BL Smith.
2002 Deaths:Final Data for 2000. *National Vital Statistical Report*. 50:15:1-119.
- Mohrmann, C.C., E.A. Coleman, S.K.Coon, J.E. Lord, J.K. Heard, M.J. Cantrell and E.C. Burks.
2000 An Analysis of Printed Breast Cancer Information for African American Women. *Journal of Cancer Education* 15(1):23-27.
- Molnar, Stephen.
1992 *Human Variation: Races, Types, and Ethnic Groups* 3rd ed. Englewood Cliffs:Prentice Hall.
- Montague Ashley.
1997 *Man's Most Dangerous Myth: The Fallacy of Race*. London. Oxford University Press.
- Moore, Henrietta.
1988 *Feminism and Anthropology*. Minneapolis. University of Minneapolis Press.
- Moore, R.J.
2001 African American Women and Breast Cancer:Notes From A Study of Narrative. *Cancer Nursing*. 24(1):35-42.
- Mullins, Leith.
1997 *On Our Own Terms*. New York:New York:Routledge
- Mukhopadhyay Carol G and Yolanda T. Moses.
1997 Reestablishing Race in Anthropological Discourse. *American Anthropologists*. 99:(3):517-533.

Mwaria, Cheryl.

- 2001 Biomedical Ethics, Gender and Ethnicity Implications For Black Feminist Anthropologists Black Feminist Anthropology: Theory, Politics, Praxis and Poetics. (Irma McClaurin, ed.) New Brunswick: Rutgers University Press.

Nattinger, Ann B., Mark S. Gottlieb, Judith Veum, David Yahnke, and James S. Goodwin.

- 1992 Geographic Variation in the Use of Breast-Conserving Treatment for Breast Cancer. *The New England Journal of Medicine* 326:(17):1102-1107.

Nickens, Herbert.

- 1997 Black Issues in Higher Education, 13:12:56-57.

Olsen, Sharon J., and Marilyn Frank-Stromberg.

- 1994 Cancer Prevention and Screening Activities Reported by African-American Nurses. *Oncology for Nursing Forum* 21:(3):487-494.

O'Malley Michael S., Joanne A. Earp and Sarah T. Hawley.

- 2001 The Association of Race/Ethnicity, Socioeconomic Status and Physician Recommendation for Mammography: Who Gets The Message About Breast Cancer Screening? *American Journal of Public Health* 91:(1):49-54

O'Malley Michael, Joanne A. Earp and Russel Harris.

- 1997 Race and Mammography. Use in Two North Carolina Counties. *American Journal of Public Health*. 87:(5):782-786.

Ortner, Sherry

- 1981 *Sexual Meaning and the Sexual Construction of Gender and Sexuality.* (Sherry Ortner and Harriet Whitehead editors) New York: Cambridge University Press.
- 1974 Is Female to Male As Nature is to Culture? In M. Rosaldo and L. Lamphere (eds.) *Woman, Culture and Society*. Stanford: Stanford University Press. pp 67-88.

Oyserman, Daphna and Kathy Harrison.

- 1997 African American Identity in Adolescence. *African American Perspectives*. 5:(1):57-67.

Padgett, DK, MJ Yedidia, J Kerner and J Mandelblatt

- 2001 The Emotional Consequences of False Positive Mammography: African American Women's Reactions in their Own Words. *Women Health*. 33(3-4):1-14.

- Pelto, Pertti J.
1970 *Anthropological Research. The Structure of Inquiry.* New York.Harper and Row.Publishers
- Pergament, Kl., DS. Ensing,K. Falgout,H. Olsen,B. Reily,K. Van Haitsma and R. Warren.
1990 God Help Me: I, Religious Coping Efforts as Predictors of The Outcomes to Significant Negative Life Events. *American Journal of Community Psychology* 18:793-824.
- Perkins, Penny, Catherine D. Cooksley and James D. Cox.
1997 Breast Cancer Is Ethnicity an Independent Prognostic Factor for Survival. *American Cancer Society*, 78:6:1241-1247.
- Perkoff, Gerald T.
1997 *The Boundaries of Medicine.* In *The Social Medicine Reader*, (Gail E. Henderson, Nancy M.P. King, Ronald R. Strauss, Sue E Estroff, Larry R Churchill (eds).Durham:Duke University Press: pp 254-277.
- Philips, J.M., M.Z. Cohen, and G.Moses.
1999 Breast Cancer Screening and African American Women: Fear, Fatalism and Silence. *Oncology Nursing Forum*, 26:3:561-71.
- Polednak, Anthony.
1989 *Racial and Ethnic Differences in Disease.*New York.Oxford University Press.
- Powe, Barbara D.
1995 Cancer Fatalism Among Elderly Caucasians and African Americans. *Oncology Nursing Forum*, 22:9:1355-1359.
- Powdermaker, Hortense.
1966 *Stranger and Friend: The Way of an Anthropologist.* New York, W.W. Norton and Company.
- Proudman, Sheila and Marilyn Barstow
1999 *National Action Plan on Breast Cancer Etiology* Working Group. Washington, D.C: ROW Sciences.
- Rapp, Rayna.
1998 Accounting for Amniocentesis. In *Understanding and Applying Medical Anthropology.*(Peter J. Brown ed.), Mountain View Mayfield Publishing Company, pp 366-374.

- Rathore SS, DL Ordin and HM Krumholz
 2002 Race and Sex Differences in the Refusal of Cardiac Catheterization Among Elderly Patients Hospitalized With Acute Infarction. *American Heart Association Journal*. 144:5:1052-1056.
- Rawl SM, VL Champion, U Menon and JL Foster.
 2000 The Impact of Age and Race on Mammography Practices. *Health Care Women International*. 21(7):583-597.
- Reid, Pamela Trotman and Lillian Comas-Diaz.
 1990 Gender and Ethnicity: Perspectives on Dual Status. *Sex Roles. A Journal of Research*. 22:(7/8):397-408.
- Riley-Eddins, Essie A., Sevan Hobfoll, and Anita Jackson.
 2000 Ways of Coping Among Low-Income Inner City Women: The Multi-Axial Model of Coping. *African American Research Perspectives* 6:(1):30-40.
- Rimmer, JH., T Nicola, B Riley, and T Creviston.
 2002 Exercise Training For African Americans With Disabilities Residing in Difficult Social Environments. *American Journal of Preventative Medicine*. 23:4:290-295.
- Ritenbaugh, C. and CS Goodby
 1989 Beyond the Thirty Gene: Metabolic Implications of Prehistoric Migration into the New World. *Medical Anthropology*. 11:3:227-236.
- Roberts, Dorothy.
 1997 *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York: Vintage Press.
- Robinson, Robert G., Larry G. Kessler and M. Farlene Naughton.
 1991 Cancer Awareness among African Americans: A Survey Assessing Race, Social Status and Occupation. *Journal of the National Medical Association*, 83:(6):491-497.
- Rodgers-Rose, La Francis (ed)
 1980 *The Black Woman*. Beverly Hills, California: Sage.
- Rollins, Judith.
 1985 *Between Women, Domesticity and Their Employers*. Philadelphia, Pennsylvania: Temple Press.
- Roseberry, William
 1989 *Anthropologies and Histories: Essays in Culture, History and Political Economy*. New Brunswick: Rutgers University Press.

Rosser, Sue.

- 1985 Women in Science and Healthcare: Gender Risk, In Feminism Within the Science and Health Care Professions: Overcoming Resistance, (Sue V. Rosser,ed), Oxford Press:Pergamon Press.
- 1992 Biology and Feminism: A Dynamic Interaction. New York: Macmillan Publishing.
- 1994 Women's Health - Missing from U.S. Medicine, Bloomington:Indiana University.

Royak-Schaler, R. and BM deVellis, JR, Sorenson, KR Wilson, DR Lannin, and JA Emerson.

- 1995 Breast Cancer in African American Families Risk: Perception, Cancer Worry and Screening Practices of First-degree Relatives Cancer Prevention From the Laboratory to the Clinic: Implications of Genetic, Molecular and Preventive Research. Leon Bradlow, Michael P. Osborne (eds.)Annals of the New Academy of Sciences.768:281-285.

Rubel, Arthur.

- 1998 The Epidemiology of Folk Illness: Susto In Hispanic America.Ethnology 3:268-283.Understanding and Applying Medical Anthropology. Peter J. Brown, 196-206 Mountain View: Emory University Press.

Russell, Kathy, Midge Wilson and Ronald Hall.

- 1991 The Politics of Women and Medical Care. The New Our Bodies, Ourselves. New York. Touchstone Books.

Sacks, Karen

- 1974 Engels Revisited:Women the Organization of Production and Private Property. (In) Woman, Culture and Society. M. Rosaldo and L.Lamphere (eds). Stanford:Stanford University Press. pp 207-222.

Sacks, Oliver.

- 1995 An Anthropologist on Mars. Seven Paradoxical Tales. New York Alfred A. Knopf.

Sahlins, Marshall D

- 1988 *Evolution: Specific and General*. (In) *High Points in Anthropology* (2nd edition) Paul Bohannan and Mark Glazer (eds). New York: McGraw-Hill, Inc. pp356-376.

Salk Hilary, Wendy Sanford, Norma Swenson and Judith Luce

- 1984 *The Politics of Women and Medical Care. Our Bodies Our Selves*. Touchstone Books. New York: Simon and Schuster.

Savitt, Todd.

- 1978 *The Diseases and Health Care of Blacks in Antebellum Virginia: Medicine and Slavery*. Chicago. University of Illinois Press.
- 1999 *A Journal of Our Own, The Medical and Surgical Story of an African-American Medical Profession in Late 19th Century America, Part one*. *Journal of the National Medical Association*, 88:1:52-60.

Scheper-Hughes, Nancy and Margaret M. Lock

- 1998 *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*, In *Understanding and Applying Medical Anthropology*. (Peter J. Brown ed). Mountain Mayfield, Ca: Mayfield Publishing Company pp.208-221.

Schulman, Kevin

- 2002 *A National Survey in Provisions in Clinical Trial Agreements Between Medical Schools and Industry Sponsors*. *New England Journal of Medicine* 347(17):1335-1341.

Sergeant, Carolyn F., & Thomas M. Johnson

- 1994 *Medical Anthropology: Contemporary Theory & Method* (revised edition), Westport: Presger.

Sheriff, Robin.

- 2001 *Exposing Silence as Cultural Censorship: A Brazilian Case*. *Journal of The American Anthropological Association* 102(1):114-132

Shea S., D Misra, MH Ebrlich, L., Field, CK Francis.

- 1992 *Correlates of Nonadherence to Hypertension Treatment in an Inner-City Minority Population*. *American Journal of Public Health*. 82(12):1607-12.

Sidel, V.

- 1993 *From Helping the Victim to Blaming the victims: Lessons from Chile and the Bronx. A New Dawn in Guatemala*. Illinois. Waveland Press Inc. 205-218.

- Siegel, K. and E. Gorey.
1997 HIV Infected Women:Barriers to AZT Use. *Social Science Medicine* 5(1):15-22.
- Singer, Merrill.
1998 *Beyond the Ivory Tower Critical Praxis in Medical Anthropology, In Understanding and Applying Medical Anthropology*, (Peter J Brown, ed), Mountain View:Mayfield Publishing Company.
- Singer Merrill and Baer Hans
1995 *Critical Medical Anthropology*. Amityville:Baywood Publishing Company, Inc.
- Simon, Robin W.
1994 Parental Role Strains, Salience of Parental Identity and Gender Differences in Psychological Distress. *Journal of Health and Social Behavior*. 33:(1):25-35.
- Smedley, Brian D, Adrienne Y. Stith and Alan R. Nelson (eds.)
2002 *Unequal Treatment:Confronting Racial and Ethnic Disparities in Health Care*.Institute of Medicine of the National Academies.Washington,D.C.:The National Academies Press.
- Smith, S., E. Trapido, S. Richman, A. Jean-Francois, S. Lojko and S. McCoy
1996 Use of Tumor Registry Data in Minority Health Programs. *Journal of Registry Management* 23: 86-95.
- Smith, A. Wade.
1993 *Survey Research on African Americans. Race and Ethnicity in Research Methods*. John H. Stanfield II and Rutledge M. Dennis, ed.Newbury Park:Sage.
- 1981 *Medical Beliefs and Their Implications for Care of Patients: A Review Based on Studies Among Black Americans*. In *Transcultural Health Care* (Henderson G. and M. Primeaux eds.) Menlo Park:Addison-Wesley Boulder. Boulder pp78-101.
- Snow, Loudell.
1993 *Walkin' Over Medicine*. Colorado.Westview Press.
- Smyth K and HN Yarandi.
1996 Factor Analysis of the Ways of Coping Questionnaire for African American Women.*Nursing Research*.45:1:25-29.

- Sondik, E.J.
1994 Breast Cancer Trends, Incidence, Mortality and Survival. *Cancer*, 74:(3), pp 995-999.
- Spring, Anita.
1995 *Agricultural Development and Gender Issues in Malawi*. Lanham: University Press of America.
- St. Jean Yanick and Joe R Feagin.
1998 *Double Burden: Black Women and Everyday Racism* Armonk, New York. M.E. Sharpe.
- Terrelonge Pauline.
1998 Feminist consciousness and Black Women. (In) *Words of Fire. An Anthology of African-American Feminist Thought*, Beverly Guy-Sheftall. New York, New York: The New Press, pp 490-501.
- Thompson, M.L., D. Lawson, M. Crougham-Minihane, and M. Cooke.
1999 Do Patients Ethnic and Social Factors Influence the Use of Do Not Resuscitate Orders? *Ethnicity and Disease* 9(1) 132-139.
- Tuana, Nancy.
1989 *Feminism and Science*. Indianapolis: Indiana University Press.
- Tylor, Victor.
1969 *The Ritual Process: Structure and Anti-Structure*. Chicago Aldine Publishing Company.
- Underwood, Sandra Million.
1999 Breast Cancer Screening Among African American Women: Addressing the Needs of African American Women With Known and No Known Risk Factors. *Journal of National Black Nurses Association*. 10:1:46-55.
- Van Dijk, Teun A.
1993 Analyzing Racism, Through Discourse Analysis: Some Methodological Reflections. In *Race and Ethnicity in Research Methods*. (John H. Stanfield II and Rutledge M. Dennis eds). Newbury Park. Sage Publications pp. 92-134.
- Veal, Yvonne Smith.
1995 A Million Voices For Health Care; Strengthening the Health Values of Behaviors of African Americans. *Journal of National Medical Association*, 88:(1):12-14.

- Wade, Jay.
1998 African American Men's Gender Role Conflict: The Significance of Racial Identity. *Sex Roles* 34:(1-2),17-33.
- Wallace, Michelle.
1995 Anger and Isolation: A Black Feminist Search for Sisterhood. *Words of Fire*. (Beverly Guy-Sheftall ed). In *An Anthology of African American Feminist Thought* New York: New York Press. p. 212-227
- Wardlow, Holly and Robert H. Curry.
1996 Sympathy for My Body. Breast Cancer and Mammography at Two Atlanta Clinics. *Medical Anthropology* 16:319-340.
- Weller, Susan C. and A. Kimball Romney.
1988 *Systematic Data Collection*. Newbury Park:Sage Publications.
- West, Cornell.
1994 *Race Matters*. New York:Vintage Books.
- Whitman S., D. Ansell, L. Lacey, E.H. Chen, N. Ebie, J. Dell, and C.W. Phillips.
1991 Patterns of Breast and Cervical Cancer Screening at Three Public Health Centers in an Inner City Urban Area. *American Journal of Public Health* 81:(12), pp 1651-1653.
- Wilson, Melvin N.
1998 Parenting and Parent-Child Interactions in African American Families: A Synopsis. *African American Research Perspectives* 4:1:7-14.
- Wilson, Midge and Kathy Russell.
1997 *Divided Sisters: Bridging The Gap Between Black Women and White Women*. New York. Anchor Books.
- Wilson, RP, A. Freeman, MJ Kazda, TC Andrews, L. Berry, PA Vaeth, and RG Victor.
2002 Lay Beliefs About High Blood Pressure in A Low-To-Middle Income Urban African American Community:An Opportunity For Improving Hypertension Control. 112(1)26-30.
- World Health Organization.
1985 *Women Health and Development: A Report by the Director-General*. Geneva: World Health Organization.

Wyatt, Gail Elizabeth.

1998 *Stolen Women: Reclaiming Our Sexuality, Taking Back Our Lives.*
New York, New York: John Wiley & Sons.

Wyatt, Gail Elizabeth and Sandra Lyons-Rowe.

1990 African American Women's Sexual Satisfaction as a Dimension of
Their Sex Roles 22(7/8), pp. 509-523.

Young, Alan.

1993 *The Cancer Puzzle: An In-Depth Exploration of Cancer and It's
Prevention, Treatment and Causes.* Portland, Frank Amato
Publications.

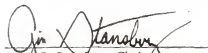
Zhu K., S.Hunter, LJ Bernard, K. Payne-Weeks, CL Roland and RS Levine.

2000 Recruiting Elderly African American Women in Cancer Prevention
and Control Studies: A Multifaceted Approach and It's Effectiveness.
Journal of National Medical Association. 92:4:169-175.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, for the degree Doctor of Philosophy.



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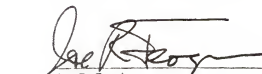
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This dissertation was submitted to the Graduate Faculty of the Department of Anthropology in the College of Liberal Arts and Science and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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